THE CIVILIAN HEALTH AND MEDICAL PROGRAM FOR THE UNIFORMED SERVICES (CHAMPUS)

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June 1975

NAVAL POSTGRADUATE SCHOOL
Monterey, California

THESIS

THE CIVILIAN HEALTH AND MEDICAL PROGRAM
FOR THE UNIFORMED SERVICES
(CHAMPUS)

by

Leland Richard Maassen

June 1975

Thesis Advisor: David R. Whipple

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The Civilian Health and Medical Program For Uniformed Services (CHAMPUS)

by

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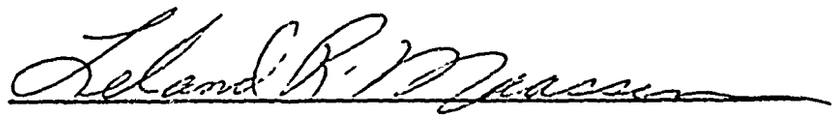
Author 

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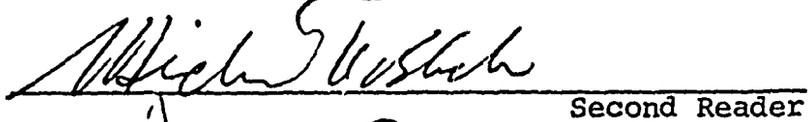
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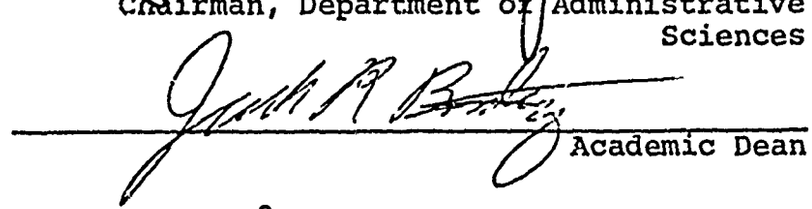
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ABSTRACT

A study of the Civilian Health and Medical Program for the Uniformed Services (CHAMPUS) was conducted to identify the structure and organizational relationships existing within the Program.

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I. INTRODUCTION

A major concern to every person in the United States is the availability of health care and how to pay for it. This is especially true for the head of a family. In the civilian community the household makes financial provisions for the health care needs of the family by purchasing some form of health insurance. The family man in the military is in the rather unique position of not having to purchase health insurance. He knows that his dependents can receive medical care at the nearby military medical facilities at a nominal daily cost for inpatient care and at no cost for outpatient care. If his dependents do not live near a military facility, medical care can be obtained at the nearest civilian medical facility at a minimal cost for inpatient care, and, once a small yearly deductible has been paid, for one-fifth the market cost of outpatient care, through the Civilian Health and Medical Program for Uniformed Services or CHAMPUS.

CHAMPUS is nearing the end of its eighteenth year of existence. In that period of time over $3,095,000,000 has been paid to the program's several fiscal intermediaries. Of that amount, $1,827,000,000 was expended prior to the end of Fiscal Year 1971. The remainder, some $1,268,000,000 was expended in the next three fiscal years.

In Calendar Year 1967, dependents of active duty and retired members and retired military personnel submitted

approximately 178,000 claims for hospital and professional services. By the end of Calendar Year 1974 the total number of claims processed for that category had risen to more than 2,814,000. By the end of July 1974, the total number of claims processed over the life of the CHAMPUS Program exceeded 20,727,000.

Most of the senior military and civilian officials of the Department of Defense consider the CHAMPUS Program an important factor in the recruiting and retention of career members of the Armed Forces. With the advent of the "All Volunteer Forces" concept its importance has become even greater. On the other hand, critics of the program claim that it is mismanaged, that people take advantage of it, and that the program is too costly. They claim, and rightly so, that the average sailor, soldier, or airman does not know about the program. In addition, Congress has taken an interest in the CHAMPUS Program. This interest, prompted by the rapidly rising costs of health care, has placed the program in the so-called "limelight."

This thesis will be the report of an indepth study of the CHAMPUS Program. Much has been written about the various health insurance plans and the HMO organizations. There have been other studies on phases of the CHAMPUS Program, but one cannot find in a single document a comprehensive description of the interrelationships between the interacting forces

involved in this military dependents and retired personnel's "health insurance" plan.

The legislative history of the program will be traced to show how the military dependents' health care program evolved from that of an emergency-care-only-in-military facilities program to one of total enfranchisement. Indepth analysis of Congressional intent and enactment of law will show the forces involved in the struggle of the birth of the program and the major changes it has undergone. The historical section will be concluded by tracing changes in Department of Defense policy as it pertains to the program.

The fiscal administrators and hospital contractors will then be examined to determine their role in CHAMPUS. The procedures used by several of the fiscal administrators to process claims will be examined to determine informational flows.

The organization of the Office of CHAMPUS will be reviewed to determine the interactions of that office with the Department of Defense, the fiscal administrators, and the beneficiaries. The past and present budgeting concepts and procedures will be studied and will show the different methods used by the Services in presenting their CHAMPUS budgets. Congressional actions will be reviewed to determine its interest in and comments on the CHAMPUS Program. Lastly, the accounting system utilized by the Office of CHAMPUS will be studied and attempts to relate dollars spent to dollars budgeted will be made. Past and present reports generated by the Office of CHAMPUS will be

examined with the goal of tracing the growth of the program.

The conclusion will describe some of the major difficulties encountered in accomplishing this study and will outline areas in which further study is needed.

II. HISTORY OF DEPENDENT MEDICAL CARE PROGRAMS

A. THE LEGISLATIVE PROCESS IN PERSPECTIVE

1. Pre-Dependent Medical Care

In 1799 the "officers, seamen, and marines of the Navy of the United States" began contributing twenty cents per month to a fund to provide for their care when they became sick or disabled [Ref. 1]. A few years later, in 1811, another law as passed that transferred the above contributions to a special "fund for Navy hospitals." Provisions of this "Act to establish Naval Hospitals" stipulated that officers, seamen, and marines on active duty or entitled to a pension would be admitted to the Navy Hospitals thus established [Ref. 2]. Since the law stipulated only active duty persons could be admitted to these newly established naval hospitals, it must be assumed that their dependents would have to obtain medical care from civilian sources. It must also be assumed that the dependent would have to pay all costs for such care.

In the Appropriations Act for the Army in 1884, the United States Congress first recognized the need for medical care for military dependents with the following proviso:

> Be it enacted by the Senate and House of Representatives of the United States of America in Congress Assembled: That the following sums be, and the same are hereby, appropriated, out of any money in the Treasure not otherwise appropriated, for the support of the Army for the year ending June thirtieth, eighteen hundred and eighty-five, as follows: ... For purchase of medical and hospital supplies, expenses of purveying depots, pay of employees, medical care and treatment of officers and enlisted men of the Army on

> duty at posts and stations for which no other provision is made, advertising, and other miscellaneous expenses of the Medical Department ... Provided, That the medical officers of the Army and contract surgeons shall whenever practicable attend the families of the officers and soldiers free of charge, and ... [Ref. 3]

But note the condition implied in the law, "at posts and stations for which no other provision is made." It is difficult to discover what is meant by this phrase but one might read a meaning into it by recalling the times during which it was written. In 1884, the Wild West was still being settled. Several Indian uprisings were recorded during that era. It would seem, then, that the proviso was aimed at caring for the dependents of Army personnel stationed at the scattered forts located in the West. Certainly one could assume from historical data that there was a scarcity of surgeons and physicians in the West during this period. There is nothing in this law pertaining to Navy or Marine Corps dependents. One must assume that since these persons normally lived in coastal towns and cities they would be expected to continue to purchase their needed medical care from civilian sources.

Fifteen years later, in a law titled "An Act to reorganize and increase the efficiency of the personnel of the Navy and Marine Corps of the United States," Congress stated, in Section 13 of that law, that, "... commissioned officers of the line of the Navy and of the Medical and Pay Corps shall receive the same pay and allowances, except for forage,

as are or may be provided by or in pursuance of law for officers of corresponding rank in the Army ..." [Ref. 4] The Navy interpreted this law to mean that medical personnel in the Navy's Medical Department could treat dependents of Navy and Marine Corps personnel in Navy medical facilities. Since this Navy Department policy was geared to the Army Appropriation Act of 1884, it must be assumed that Navy and Marine Corps dependents could receive care only at those commands that had naval medical facilities. The phrase "shall whenever practicable" seems to be the guiding factor in determining when such care would be provided. It would also seem that such care may have been provided to only the dependents of officers since enlisted men were not addressed in the Navy Personnel Act of 1899.

In 1943 Congress took action to lay out the first really specific rules pertaining to dependent medical care. In Public Law 51, an act to expand Navy medical facilities, Congress spelled out that dependent medical care in Navy facilities would be provided "only if adequate care was not available in an appropriate non-Federal hospital." Care to be provided under those circumstances was "only for acute medical and surgical conditions, exclusive of nervous, mental, or contagious diseases or those requiring domiciliary care" [Ref. 5]. This act also defined, for the first time, the word "dependent." A dependent was to include a lawful wife, an unmarried dependent child under 21 years of age, and a mother

or father of the member if they were in fact dependent on the serviceman. Widows of deceased naval and Marine Corps personnel were entitled to the same care as were dependents. The act further stated that outside the limits of the United States, government employees and contractors and their dependents would be eligible for emergency medical care provided there were no adequate non-federal hospital facilities available nearby.

The act further specified that when naval facilities are utilized by dependents, they would be required to pay a per diem rate prescribed by the President. There is nothing in this Act that includes, or excludes, members of the Army and their dependents. The Act does state, however, that dependents of Coast Guard personnel, when that unit was operating as a part of the Navy, were included among those persons considered eligible to use Navy medical facilities. Thus, prior to the end of World War II military dependents had received the enfranchisement for medical care in military facilities, albeit for limited purposes of emergency treatment for acute conditions. It should be noted that this law permitted dependents to receive inpatient care in military facilities only if it were not available in the civilian community. One must then assume that dependents were required to purchase most of their medical care from civilian providers.

2. Dependent Medical Care - WWII to 1956

The Second World War saw the rapid expansion of the Armed Forces and tremendous leaps forward in technology. The field of medicine also benefitted as physicians learned new techniques, the "wonder drugs" of the sulfa and penicillin families came into use, and, in general, medical services provided to the sick advanced.

But, the military dependent could receive hospital care in military medical facilities only for "acute medical and surgical conditions." It was not until 1949 that the Congress again addressed itself to the problem of dependent medical care. In that year, Congressman Olin Teague of Texas authored a bill which provided that unmarried widows and children of deceased members would be authorized to receive their medical care in medical facilities of the Uniformed Services. This bill, and three others similar in nature, did not get beyond committee status. In 1952, a bill authored by Senator Herbert H. Lehman, was introduced to the Congress. This bill would have permitted the wives and children of enlisted personnel to receive maternity and child care benefits [Ref. 6].

The Defense Department advocated extending the bill to include dependents of officers up to the O-3 pay grade. Opposition to this bill was led by the American Hospital Association who felt that in the near future the majority of the nation's population would be servicemen, veterans, or their dependents. They voiced the fear that "we shall have

socialized medicine without necessity of specific legislation for it" [Ref. 7]. The American Medical Association strongly opposed the bill also. They objected to it "on the grounds no emergency exists and communities can take care of these families" [Ref. 6].

This bill was strongly supported by the American Legion, the American Red Cross, and the Defense Department. The American Legion testified that military installations could provide maternity care for less than one-third of the expected births in 1952. Defense officials testified that military families would have 200,000 births in 1952 and that maternity care could be provided for only 75,000 of them. The American Red Cross indicated that it would be able to furnish financial assistance to only 10,000 military families for maternity care. The remaining families, it was implied, would have to depend on charitable institutions, or worse, either accept less-than-adequate care or no care at all.

In spite of the favorable testimony, the A.M.A. and the A.H.A. views prevailed and the bill was not acted upon prior to the end of the legislative year. In early 1953, the Citizens Advisory Commission on Medical Care for Dependents of Military Personnel referred to as the Moulton Commission made its report to the Secretary of Defense. In it the Commission expressed concern over inequalities of medical care for dependents and recommended civilian doctors and hospitals be used to supplement family medical care given at military

medical facilities [Ref. 8]. The Department of Defense prepared legislation based on these recommendations and sent it to Congress where it was sponsored by Senator Leverett Saltonstall.

Major provisions of this bill required dependents to pay the first $20 plus not more than 10 percent of the total costs of care received at civilian facilities. Maternity care, however, would be entirely paid for by the government. Another section of the bill defined the term "members" of the Armed Forces. There was to be three categories of members of the Armed Forces. The first category included active duty members of the Army, the Navy, the Air Force, the Marine Corps, and the Coast Guard when it was serving as a part of the Navy. Members of reserve components on active duty in excess of 30 days made up the second category and members in a retired or retainer pay status comprised the third category.

The bill also contained the provision that the Secretary of Defense could contract with private insurance companies for dependent care if it could be shown that such plans would be more economical [Ref. 9].

In laying the groundwork for the introduction of this bill, John A. Hannah, Assistant Defense Secretary, had previously testified before Congress that "it has been established plainly that worry about the health of dependents and the availability of adequate care for them in times of sickness or accident has an adverse effect upon morale, particularly

that of men separated from families while on duty overseas" [Ref. 10]. Hearings on this bill were delayed because the Defense Department had not submitted a cost estimate. No further action was completed in that legislative year.

In January 1955, Congressman Carl Vincent introduced a bill in the Committee on Armed Services that was essentially the same as the Saltonstall bill. The bill was designed, according to Defense Department officials, to equalize medical care provided to dependents of Armed Forces personnel [Ref. 11].

As a counter-force to this bill, the Hoover Commission of 1955 advocated the elimination of free hospital medical care for dependents of all servicemen in the United States and suggested a plan for a contributory health insurance system for service families. The suggestion did state, however, that the government would defray part of the cost. This purely voluntary program had a slight catch to it. Those persons who did not take out commercial health insurance would not be eligible for care in civilian facilities. In addition, they would be barred from inpatient care at military medical facilities. The Commission's rationale was that the serviceman had the right and privilege to accept or decline participation in the insurance program it had suggested [Ref. 12].

Opposition by the American Medical Association and the effect of the publicity surrounding the issuance of the Hoover Commission Report forced a revision in the Vincent Bill. This revision resulted in an entirely new bill being

introduced into Congress. The new bill allowed dependents medical care in military facilities as long as there was space and staff personnel available. The medical care that they could receive would be limited, as before, to treatment of acute medical and surgical conditions. If space or staff were not available, the dependent had to get a certificate stating that fact and that care in civilian facilities was authorized. The dependent would then have to share in the costs of civilian care by paying the first $10 plus 10 percent of the total cost for each illness [Ref. 13].

In August 1955, the Defense Department's dependent medical care bill was reintroduced into Congress. This year's bill had essentially the same provisions as its predecessors except it called for an insurance program in which the military families contributed up to 30 percent of the monthly premium. A family would not, however, contribute more than the maximum of $3.00 per month. Another new option provided that if no military medical facilities were available and the member declined the insurance program, his dependents could get civilian medical care. The serviceman would be required to pay 30 percent of the first $100 of hospital care and 15 percent of the remaining costs. Outpatient care would cost the member 30 percent of all costs incurred by his dependents [Ref. 14]. A dramatic change in the wording of this bill was the exclusion of widows and children of deceased military personnel as eligible beneficiaries.

In early 1956 still another revised bill for dependent medical care was introduced into Congress by Congressman Vinson. This bill dropped the option that authorized care in civilian hospitals on a payment plan partially subsidized by the government. The bill would allow medical care for dependents at existing medical facilities and provided the opportunity for all military personnel to participate in a basic health insurance plan for wives and children. Additional optional insurance policies would become available for coverage of dependent parents and parents-in-law and for coverage of long-term care diseases such as polio or tuberculosis [Ref. 15]. The basic insurance plan was to cost the serviceman about $3.00 per month. The cost of the entire premium of the optional policies, if purchased, would be borne by the serviceman.

At hearings on this bill Defense officials stressed the need for dependent medical care as an important morale factor. At the same time these officials insisted that the Armed Forces still wanted to give medical care to dependents at military medical facilities, both as a historic responsibility and as a necessity to the professional efficiency of their physicians [Ref. 16].

By mid-February 1956, the House Armed Services Subcommittee had finished its public hearings and went into closed session to write a finished version of the bill. The final version of the bill, when compared to the previous bills, was

considered as a very liberal bill. The bill, as reported by the Kilday Subcommittee, contained the following important provisions:

a. Dependents would be classed as one of two categories, active duty or retired, without regard to the branch of service of the military man.

b. The government must pay for group insurance for a specific list of services for dependents of servicemen who could not get such care in Defense Department or Public Health Service medical facilities.

c. The government was to work out insurance coverage for dependent parents and the dependents of retired and deceased persons.

d. The dependents would have to pay the first $25 of civilian inpatient hospital costs for each illness.

e. All government medical facilities would charge a uniform per diem subsistence rate to dependents who received inpatient care.

f. Government medical facilities would be open to all dependents regardless of the service affiliation of their sponsor.

g. Coast Guard dependents could utilize Defense Department medical facilities and vice versa.

h. Government medical facilities could make a modest charge to dependents for outpatient care to discourage abuse of the privilege.

i. Retired personnel may receive medical and dental care at government medical facilities subject to the availability of space and staff.

The minimum care to be contracted from insurance plans would be restricted to inpatient care and would include:

a. Hospitalization in semi-private accommodations for not more than 365 days,

b. All necessary services and supplies,

c. Medical and surgical care incident to the hospitalization,

d. Complete maternity care,

e. The required services of a physician or surgeon before and after hospitalization for bodily injury or an operation.

f. Diagnostic tests incident to hospitalization [Ref. 17].

This bill was rapidly approved by the House Armed Services Committee and had passed the House of Representatives by late February 1956 [Ref. 18]. The Senate, however, had different ideas. Their version of the dependents' medical care bill eliminated eligibility for all dependents other than the wives and children. It added Title III Reservists, who had retired with less than eights years of active duty, to the list of persons eligible for care in Defense Department medical facilities. The Senate version further set as the maximum limits of allowable care those limits which the House

had said should be the minimum. A final feature changed the payment plan for civilian inpatient care to $1.75 per day or $25.00, whichever was the greater amount [Ref. 19]. A major factor that was considered, the Senate Armed Services Committee reported, was the liberal medical care privileges private industry was extending in its insurance plans and the large increase in the number of dependents needing care which had resulted in the overloading of some military medical facilities [Ref. 20].

In early May 1956, the Senate had approved their version of the bill and, by the end of the month, a Congressional Conference Committee compromise bill had been approved by both houses of Congress [Refs. 21, 22]. Presidential approval was received in June. Public Law 84-569, the Dependents' Medical Care Act, repealed the proviso in the Army Appropriations Act of 1884 and portions of the Act of 10 May 1943 which pertained to naval personnel. The Navy had stopped deducting money from the pay of Navy and Marine Corps personnel in 1944 in order to simplify accounting procedures although the Acts of 1799 and 1811 had not formally been repealed.

By October 1956, the Defense Department had readied its regulations to implement Public Law 569. Under these regulations, dependents would be provided "Dependents Authorization for Medical Care" cards naming the eligible wife and children [Ref. 23]. Everyone was certain that this law " . . assures hospital care at all times to the wives

of active duty personnel. It removes one of the greatest sources of worry to our servicemen and servicewomen around the world" [Ref. 24]. Outpatient care was not, however, addressed in this law. Such care, it must be assumed, had to be obtained from civilian providers with the dependent paying the full cost.

3. Dependent Medical Care - 1956 to 1966.

One of the most controversial provisions of the Dependents' Medical Care Act was that which allowed all military dependents "free choice" in the selection of either military or civilian hospitals for their inpatient care. This provision, inserted into the law on the recommendation of the American Medical Association, was the first to be attacked by members of Congress. In 1958 the House Appropriations Committee directed that a limitation be placed on this provision. They felt that military medical facilities "are not being used to their optimum economic capacity [Ref. 25]." To stress their concern they imposed a ceiling of $60 million on the Fiscal Year 1969 Dependent Medical Care expenditures. The Senate Appropriations Committee agreed with the House on the spending limit. The full Senate, however, did not agree. The appropriation act for that year for dependent medical care was $12 million over the ceiling desired by the House of Representatives. In the Joint Conference Committee, the Senate action prevailed, but, at the insistence of the House,

the bill contained a warning that military facilities must be more fully utilized [Ref. 26].

In response to the congressional criticism the Secretary of Defense issued a directive which ordered "rigid restrictions on the use of MediCare by dependents." The directive required dependents residing with their sponsors to "utilize uniformed services medical facilities if available and adequate [Ref. 27]." If such facilities were not available, the dependent had to receive a permit from the local commander in order to obtain "authorized care from civilian sources at government expense." The only exception allowed to this requirement was for bona fide emergency conditions. The directive further specified several types of medical care which would no longer be considered as authorized benefits of the Program. Those types of care which were eliminated were:

a. The treatment of fractures, dislocations, lacerations and other wounds which were normally treated on an outpatient basis.

b. Termination visits made to a physician's office prior to final discharge from his care.

c. Pre- and post-surgical tests and procedures which were normally accomplished as an outpatient.

d. Neonatal visits for "well baby" checkups.

e. The treatment of acute emotional disorders.

f. All elective surgery including non-acute tonsillectomies, hernias, and interval appendectomies.

Other congressional action in 1958 amended Title 10 of the United States Code. Chapter 55 was amended by the insertion of a statement of purpose into the law. After the amending action the statement read, in part, " . . . to create and maintain high morale in the uniformed services by providing an improved and uniform program of medical and dental care for members and certain former members of those services and for their dependents." Congress also added a sixth category of authorized care. This amendment allowed inpatient care for up to one year for "special cases" of nervous, mental, or chronic conditions. These "special cases" could not, however, include domiciliary care [Ref. 28].

In Fiscal Year 1960, the Dependent Medical Care budget requested by the Department of Defense and approved by Congress was $88.8 million [Ref. 29]. In addition, all of the services eliminated in October 1958 were fully restored as of 1 January 1960. The MediCare Permit was retained, but was given a new name. It was to be known as a Non-Availability Statement [Ref. 30]. By mid-1960 it was apparent that the costs of the Dependent MediCare would continue to rise. The size of families was growing rapidly and the costs of medical care in civilian facilities was rising at a rapid rate [Ref. 31]. During Fiscal Year 1961, the number of eligible family members would exceed 3.74 million, more than 200,000 above the level of eligible persons in 1959. Projected population figures for Fiscal Year 1962 would add another 80,000

persons to the list of those eligible for dependents medical care [Ref. 32].

An important area of contention between Congress and the Defense Department during this time period involved the question of programming of dependent care facilities in new military medical facility construction. The Secretary of Defense, in 1961, had ordered the elimination of such features from the plans of future medical facilities [Ref. 33]. By the middle of 1962 he had rescinded his order because of the impact that their elimination would have had on the overall cost of the Dependent Medical Care Program [Ref. 34]. Throughout the latter part of 1963 and the early months of 1964, both the Department of Defense and Congress completed several studies of the Dependent Medical Care System. The primary concern of these studies was the lack of medical care for retired personnel and their dependents. The 1956 law allowed retired persons to obtain medical care in military facilities on a "space available" basis. It did not permit them to use civilian medical facilities other than at their own expense. The rapidly growing number of retired persons and dependants had resulted in creating a heavy demand on the already crowded military medical facilities. In response to this demand, and as a result of numerous studies, the Defense Department sent a proposal for retirees medical care to Congress in June 1964. Congress, the proposal declared, had a "moral obligation" based on historical precedents and other considerations to

"endorse government sponsored medical plans for retired persons." The Defense proposal suggested four possible solutions to the problem.

a. Congress could extend the provisions of the Dependent Medical Care Act of 1956 to include the retired population. The retirees deductible payments would be $100 or even $150 versus the $25 that active duty persons paid.

b. Congress could direct that all retired care would be at military facilities only. Such care would be on the basis of a priority system; those retired with 30 or more years of service or for medical disability would receive the highest priority.

c. Congress could initiate a special type of Federal Employees Health Insurance Plan. This plan would offer several choices: a government-wide benefits-in-kind program, a government-wide indemnity plan, employees' organizations plans (group practice plans), or a combination of the best features of all of the plans.

d. The last proposal was a combination of the first two proposals and would permit the military to program 10 percent of all hospital beds in new construction for retired use. The remainder of the retirees and their dependents could use the Dependent Medical Care System [Ref. 35].

A special House Armed Services Subcommittee under the chairmanship of Congressman L. Mendel Rivers, in its report to the House of Representatives on the Utilization of

Military Medical Facilities stated that the government did indeed have an obligation to provide medical care to military personnel and to their dependents. The report, issued in the latter part of 1964, further declared that in the future, hospital beds should be "programmed on estimated workloads in all categories of personnel eligible for care [Ref. 36]." This last statement is a little ambiguous since another recommendation in the report required that no beds or inpatient facilities should be programmed for retired persons or their dependents. The committee's report also stated, "it is clear to the subcommittee that in future years a major portion of care must come from civilian facilities if it becomes governmental policy to provide such care."

As a result of the studies and special hearings on dependent medical care, three separate bills were introduced in Congress in the early months of 1966. One of the bills was for medical care for retirees and their dependents. It would require eligible persons to pay 25 percent of all medical care costs. It also contained a provision that made the wives and children of deceased military persons eligible for medical care. Another important provision of this bill specified that all retirees would lose their eligibility for such medical care at age 65 when they would become eligible for the Social Security MediCare System. If for some reason they did not qualify for Social Security benefits, they would be covered under the provisions of this particular bill [Ref. 37].

A second bill provided for care of handicapped children of active duty personnel. Types of care which would be authorized included residential care for training, rehabilitation, and special education for the moderately, severe, and profoundly retarded or seriously physically handicapped children. The serviceman would pay between $25 and $250 per month, depending on his rank, as his share of the total cost of such care.

The third bill introduced was to provide outpatient medical care for dependents of active duty personnel. If this care was obtained from civilian facilities, the serviceman would pay 20 percent of the total cost. Outpatient care would be free on a space available basis, as it had been for many years, in the military medical facilities. This particular type of benefit had been considered by Congress during the enactment of the 1956 law but was not included in the final version of that law because, as Secretary of Defense Cyrus Vance later explained:

> Inclusions of such benefits was not a common practice in group health plans then being offered by industry and labor.
>
> Many types of cases which ten years ago would have been treated on an inpatient basis are now treated on an outpatient basis. Another significant development during the interim was the establishment of the Federal Employees Health Benefits Program, under which the dependents of civilian employees of the Government receive civilian outpatient care.
>
> It is clear that while the practice of medicine has changed and the benefits, including outpatient coverage offered by most health plans have been

expanding rapidly, the benefits provided under the Dependent Medical Care Program have remained frozen at the 1956 level [Ref. 39].

After several days of hearings, the House Armed Services Committee reported to the House of Representatives a single bill that encompassed the provisions of the three original bills and included several provisions that were entirely new. One of the new provisions authorized Title III retirees to receive care in the "retired medical care" category of benefits. Another provision required the Department of Defense to program five percent of all beds for the use of retirees in any future medical construction. Still another provision would require the government to pay the same amount for civilian care for dependents of retired personnel as for dependents of active duty personnel. Stated another way, this provision meant that the retirees would have the same deductible and co-payment requirements that active duty personnel enjoyed. There was also a formula under which dependent medical care would never be less than the high option of health benefits under the Social Security MediCare Plan as of the first of July of the year of enactment.

The bill also contained formulas for calculating the percentage of medical care costs which would be paid by the serviceman for treatment under the handicapped portion of the bill. These formulas assured the active duty man that payments he would be required to make for that type of care would not exceed one-fourth of the toal combined contribution

of the government and himself. Retirees, through a special saving clause, were assured that they would continue to receive whatever benefits they were entitled to prior to reaching age 65, even though they would also be covered by the Social Security benefits [Ref. 40].

In reporting the bill, Congressman F. Edward Hebert, chairman of the subcommittee that rewrote it, told the House that this bill would "give members of the uniformed services a singularly lifelong program of medical care for themselves and their families, and as such it is a foundation on which the military services can build an improved record of career retention." He also stated that the committee "believes that the program will make a great contribution to the morale of our military . . . who will have the assurance that their families, no matter where they reside, will receive first class medical care at the very minimum of cost [Ref. 41]."

The first witness to appear before the Senate Armed Services Subcommittee when it began its hearings in June 1966 was Senator Robert Kennedy. He offered an amendment that provided for broader coverage and benefits for handicapped dependents, for the inclusion of well-baby care, for psychiatric services for mentally ill persons, and authorized immunizations and physical examinations for dependents who were to accompany the serviceman overseas [Ref. 42].

Although many other witnesses spoke in favor of Senator Kennedy's amendment and in favor of the House bill,

the Senate Subcommittee severely cut the House version. The Senate version delayed the effective date by one full year, provided for a higher cost-sharing formula, and dropped the retired person's eligibility for Dependent Medical Care when he reached age 65. The cost-sharing formula desired by the subcommittee specified a $50 deductible per person, with a family maximum deductible of $100, plus 20 percent of all additional costs for outpatient care for dependents of active duty personnel. Retired persons and their dependents would have to pay the first 25 percent of all of the costs of civilian medical care that they received. The eligibility of Title III retirees and the requirement to program beds in military medical facilities for retired persons were also eliminated in the Senate's bill. Their version of the bill did, however, broaden the handicapped program passed by the House by adding mentally retarded or physically handicapped wives to the list of persons eligible to receive specialized care. Eligible persons could also receive eye examinations in military medical facilities under still another provision [Ref. 43].

The two versions of the bill went into Joint Conference Committee in mid-September 1966. By the end of the month, the final version of what would come to be known as the Military Medical Benefits Amendments of 1966 had been approved by both houses of Congress [Ref. 44]. These amendments and the Dependent Medical Care Act of 1956, as codified in Title

10, Section 1077 to 1086, United States Code, form the basis of all dependent care as it is known today.

B. DOD INTERPRETATION OF THE LAW

The first Defense regulations on the new dependent medical care program or, as it was now titled, the Civilian Health and Medical Benefits Program for the Uniformed Services (CHAMPUS) was a complex document. The regulations required the inclusion of certain specific data on all dependent and retired personnel's identification cards. It outlined the separate systems for claims submissions. Claims could be processed in one or more ways depending on the type of inpatient or outpatient care received. For inpatient care the dependent was required to complete certain parts of the claims forms at the hospital and the hospital would take care of completing the claim and submitting it to the designated fiscal agent.

For outpatient claims the process was not so simple. The dependent had to pay all of the charges up to the deductible limit. If, however, a payment to a health care provider exceeded the deductible, the dependent had to submit a claim to the proper fiscal agent (each state had a different one) with all receipted bills substantiating that the deductible limit had been paid attached to the claim form. The fiscal agent would then furnish the dependent with a certificate that stated that the deductible had been met. By presenting this certificate the next time they needed outpatient care, the

dependents would have to pay only 20 percent of the total cost of such care. The provider of the care would then submit a claim to the proper fiscal agent who would pay the government's share of the total cost [Ref. 45].

The expanded program had been in effect for less than a year when Congress and the Defense Department began considering changes to it. One of the important initial changes permitted the use of "private-profit" facilities for treating mental and physically handicapped dependents [Ref. 46]. A Department of Defense policy ruling stated that facilities that discriminated in admissions or treatment of patients "on the basis of race, color, or national origin" were no longer considered as eligible providers of care [Ref. 47]. Another policy statement included therapeutic abortions and sterilization procedures as a CHAMPUS benefit [Ref. 48]. One of the more liberal policy rulings pertained to the billing procedures to be used by providers of orthodontic care for physically handicapped dependents. Other policy statements and regulation changes which benefited dependents were the inclusion of payments for the cost of specialized equipment prescribed by a physician as being necessary to properly treat a dependent, for the services of assistant surgeons, anesthesiologists, private duty nurses in special instances, podiatrists, and psychologists, for routine dental care for expectant mothers when so ordered by a physician, and for the cost of treating alcoholism, obesity, and drug addiction if

such care was received while in an inpatient status [Refs. 49, 50, 51, 52, and 53].

A recent change was made to allow the handicapped dependents of Vietnam war dead to continue their care until age 21 or until they otherwise cease to be eligible for such care. The change applied to those dependents who were involved in a program of special care at the time of the serviceman's death [Ref. 54].

More recently, there have been several policy changes which have not benefited the dependent. One of these stated that non-availability statements would not be issued to expectant mothers who wanted to use natural childbirth procedures unless the military medical facility did not use that procedure [Ref. 55]. Another policy change required that orthodontists return to monthly billing procedures from the quarterly procedures that had been instituted a year before [Ref. 56]. One of the latest policy changes reduced the allowable benefits that a handicapped child could receive in the area of treatment termed psychotherapy [Ref. 57].

III. THE CHAMPUS ORGANIZATION

The administrative functions of the Dependent's Medical Care Program had been, since its inception, assigned to the Office of The Surgeon General of the Army. In late 1971, however, the Congress expressed its displeasure at the manner in which the program administration was being handled. They directed that the Office of the Secretary of Defense should take a more active role in that function. As a result, the Assistant Secretary of Defense (Health and Environment) was named to direct the Dependents Medical Care Program. Although that office became the titular head of the program, the actual administration continued to be accomplished by an Army Medical Officer from the Army Surgeon General's office.

The Office for the Civilian Health and Medical Program of the Uniformed Services (OCHAMPUS) is physically located on the grounds of the Fitzsimmons Army Medical Center, Denver, Colorado. It is currently situated in two converted barracks-type buildings. The OCHAMPUS staff is primarily composed of civilian personnel although there are eighteen military officers currently assigned to duty there. A memorandum from Deputy Secretary of Defense [Ref. 58] dated 4 December 1974 on the subject of CHAMPUS stated that these military billets, six Army, five Navy (includes one Coast Guard officer), and seven Air Force, would be civilianized. It is anticipated by the Acting Deputy Director that the civilianization will

be accomplished through normal attrition, that is, as the military officer assigned to the position is detached, the replacement will be a civilian.

In the same memorandum it was specifically stated that "The Director of OCHAMPUS shall be a civilian selected by the Assistant Secretary of Defense (Health and Environment)." The last designated Director of OCHAMPUS departed the command in mid-1974. Since that time an Air Force Medical Service Corps Colonel has been Acting Director and the Acting Deputy Director has been a Navy Medical Service Corps Captain. The civilian Director of OCHAMPUS, when named, is expected to be given a Civil Service GS-17 grade.

Prior to 1 July 1972, the Director of OCHAMPUS reported directly to the Surgeon General of the Army who, in turn, reported, for CHAMPUS related matters, to the Assistant Secretary of Defense (Health and Environment). The present chain of command is direct to OASD(H&E). It is direct except that OASD has established an Office of CHAMPUS Policy to which the Director of OCHAMPUS actually reports for most situations. The exception to this reporting path relates to the flow of funds. The funds used for the CHAMPUS Program previously came from the user services, i.e., the Army, Navy, Air Force. Now that the CHAMPUS appropriation is one of a few monitored and controlled directly by DOD, its funds come to OCHAMPUS from the Office of the Assistant Secretary of Defense (Administration).

As can be seen from the OCHAMPUS Table of Organization, Exhibit 1, the Director of OCHAMPUS has five offices which report to him in an advisory capacity. He alsc has four Directorates which carry out the operational aspects of the CHAMPUS Program [Ref. 59].

A. OFFICE OF THE MEDICAL AND THE DENTAL ADVISOR

These offices provide advisory services on extended care and handicapped treatment cases. They also advise the Director on, and review performance cf, Utilization and Peer Review activities of CHAMPUS contractors. They maintain contact through the respective professional medical and dental staffs that the contractors maintain.

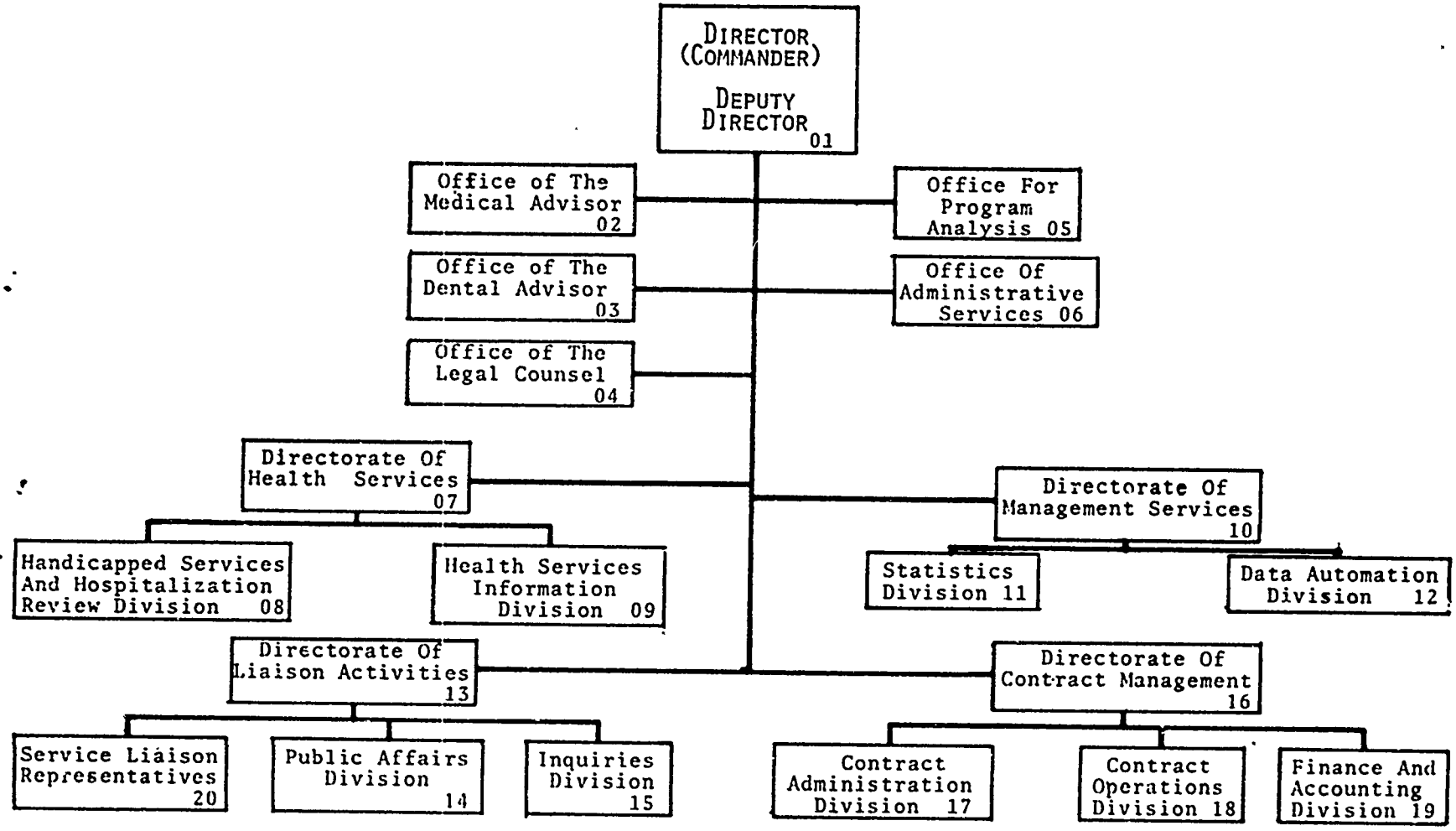
B. OFFICE OF THE LEGAL COUNSEL

The Legal Counsel examines, for legal sufficiency, all contracts with fiscal administrators for hospital and physicians' services. These examinations include all modifications, supplementary agreements, advance payment agreements, termination notices and all related contracting and procurement documentation. He also insures compliance with all applicable provisions of law, the Armed Services Procurement Regulations, and all procurement directives of higher authority. He advises the Director on all legal questions involving interpretations and monitors cases involving suspicion of fraud. He represents the Director in all legal matters requiring coordination with other federal agencies.

EXHIBIT 1

OFFICE FOR THE CIVILIAN HEALTH AND MEDICAL PROGRAM OF THE UNIFORMED SERVICES

(OCHAMPUS)



C. OFFICE FOR PROGRAM ANALYSIS

This office is the primary study group for the CHAMPUS Program. It is tasked with ongoing investigations of policies and procedures of the program with an objective of providing optimum service to the program beneficiaries at the minimum cost to the government.

D. OFFICE OF ADMINISTRATIVE SERVICE

This office provides logistic and administrative support for OCHAMPUS staff entities. The General Services Branch provides mail and messenger services and processes all incoming and outgoing correspondence. This branch also operates the records management program, carries out the supply functions for the command, and arranges for the maintenance of equipment and the OCHAMPUS buildings. The Reproduction and Housekeeping Branch provides all of the reproduction services to the command and obtains the necessary janitorial services for the OCHAMPUS buildings. The Stenographic Branch provides stenographic and clerical services to the command. They have recently installed a word processing system which involves a telephonic-call-in dictation machine. The tapes from these machines are transcribed by typists on magnetic cards which are then used to prepare smooth originals. This system allows the on-site inspectors to phone in their reports from a hotel room while the information is fresh on their mind. By the time they arrive back at OCHAMPUS, the finished report is on their desk ready for their signature.

E. DIRECTORATE OF HEALTH SERVICES

This Directorate is primarily concerned with the benefits available under the Program for the Handicapped. The Handicapped Services and Hospitalization Review Division acts on claims and requests for benefits for patients with moderate and severe mental retardation and for patients with serious physical handicaps, other than those of a dental nature. It reviews and approves or disapproves applications for extended hospitalization in excess of 90 days. Such cases involve patients with a diagnosis of some type of chronic condition, or a nervous, mental, or emotional disorder which falls under the provisions of the Basic CHAMPUS Program.

The Health Resources Information Division maintains a registry of information, including location, cost, and services provided for the use of handicapped children and other persons requiring specialized care. Sponsors, upon request, can obtain information on specialized care facilities for a given area which can provide the specific care required for an eligible dependent. This division also conducts on-site evaluations of the specialized care institutions to investigate complaints, to ascertain the quality and appropriateness of care, to ascertain the adequacy of staff and plant, and to insure compliance with pertinent lawas and accreditation standards.

F. DIRECTORATE OF MANAGEMENT SERVICES

The Management Services Directorate acts as a Management Information Systems Office and provides management information on a timely basis to all managerial elements of the OCHAMPUS staff. The Statistics Division provides statistical analysis of available data and recommends reporting formats for planning and reporting purposes. This division also makes recommendations concerning the inclusion of those items of data considered as essential for the OCHAMPUS data base. The Data Automation Division, through its Systems Design Branch, designs data automation systems and writes and maintains all of the OCHAMPUS computer programs. The Design Branch also performs feasibility-of-automation studies for various OCHAMPUS elements. The Computer Operations Branch operates the IBM 360/30 computer and peripheral equipment. It provides keypunch support, maintains input and output controls, and manages the computer tape library. This last function entails the inventory control of approximately 1,400 reels of taped programs and data.

G. DIRECTORATE OF LIAISON ACTIVITIES

This Directorate is charged with the development of an ongoing program of providing up-to-date CHAMPUS Program information to beneficiaries, to providers, to fiscal administrators, to hospital contractors, and to the several uniformed services. It also investigates and responds to complaints,

inquiries, and requests for assistance. The Service Liaison Representatives, a division of this Directorate, maintain liaison between OCHAMPUS and their respective services. They represent their service's interest to OCHAMPUS and advise and assist CHAMPUS Advisors and Health Care Counselors. They also provide assistance to other elements of the OCHAMPUS staff in handling inquiries, complaints, and requests. These representatives prepare special studies for their respective services when required or directed to do so.

The Inquiries Division's primary function is to investigate and respond to complaints and requests for information received from all sources. Another one of their functions is to submit requests to the services for eligibility determinations in questionable cases and to provide to fiscal administrators and sources of care all information concerning terminations of eligibility. The Public Affairs Division, in cooperation with the DOD information agencies, develops and manages a CHAMPUS information program. This program provides information on CHAMPUS benefits and eligibility requirements to all interested persons. They also recommend and coordinate public appearances by OCHAMPUS staff members and prepare or assist in the preparation of the member's speeches. They provide clearance for all other speeches and articles prepared by staff members and coordinate the presentation of CHAMPUS exhibits at national and local conventions.

H. DIRECTORATE OF CONTRACT MANAGEMENT

The Contract Management Directorate is responsible for all matters pertaining to contracts, except for legal matters. The Director of Contract Management exercises authority as the OCHAMPUS Contracting Officer for the United States Government. The Contract Administration Division has as its primary responsibility the administration of contracts, the development of workload data, budget estimates, and the representation of OCHAMPUS on all financial matters. They conduct on-site reviews of contractor operations. In this function they are primarily concerned with the adherence to established policy and the adequacy of service. They also monitor contractor operations through reviews of monthly claims activity reports.

The Contract Operations Division maintains liaison with the contractors, advises them on matters of policy and procedure, and performs monthly audits on selective samples of claims paid to determine accuracy of the contractor's claims processing procedures. This last function is accomplished with the assistance of the OCHAMPUS computer which generates, randomly, a series of claims numbers. The contractor is notified of these numbers and is requested to send the hard-copy claims to OCHAMPUS for review. This division also verifies contractor invoices prior to payment. They also maintain liaison with several associations and agencies which are involved in prepayment drug plans and perform administrative, consultative, and advisory work in the administration of the CHAMPUS drug program.

The Finance and Accounting Division certifies disbursement vouchers, controls all funds, maintains journals and ledgers, and prepares the financial reports. The actual operations of this division will be discussed more fully in a later chapter.

IV. CLAIMS PROCESSING - FISCAL ADMINISTRATORS

A beneficiary's first contact with the CHAMPUS system occurs when they present themselves for treatment to a participating, qualified provider. The beneficiary presents the provider with a copy of DD Form 1251, Statement of Non-Availability, issued by the local military medical facility if they are seeking inpatient care [Ref. 60]. In return, the provider, depending on the type of care being provided, has the beneficiary complete applicable portions of one of the following forms:

a. DA 1863-1, Request for CHAMPUS Payment - Hospitals (Exhibit 2).

b. DA 1863-2, Request for CHAMPUS Payment - Other Than Hospitals (Exhibit 3).

c. DA 1863-3, Request for CHAMPUS Payment - Program for the Handicapped (Exhibit 4).

d. DA 1863-4, Request for CHAMPUS Payment - Pharmacies (Exhibit 5).

The beneficiary is responsible for the completion of items one through thirteen on these forms. Items one through six pertain to patient identification data including identification card number and the effective beginning and ending dates for eligibility. Items seven through twelve pertain to the identification and duty station of the service member. Item thirteen is the certification that the preceding items are

EXHIBIT 2-A

SERVICES AND/OR SUPPLIES PROVIDED BY CIVILIAN HOSPITALS

CIVILIAN HEALTH AND MEDICAL PROGRAM OF THE UNIFORMED SERVICES (CHAMPUS)

SEE INSTRUCTIONS ON REVERSE

SECTION I *(To be completed by patient or other responsible family member. Please print or type)*

PATIENT DATA

1. NAME *(last, first, middle initial)*
2. DATE OF BIRTH
3. ADDRESS *(Include Zip Code)*
4. PATIENT IS A *(Check one)*
   ☐ (1) SPOUSE ☐ (2) DAUGHTER ☐ (3) SON ☐ (4) RETIREE
5. IDENTIFICATION CARD *(DD Form 1173, DD Form 2 or PHS Form 1868-3)*
   CARD NO
   EFFECTIVE DATE — MONTH / DAY / YEAR
   EXPIRATION DATE — MONTH / DAY / YEAR
6. BASIS FOR CARE – ACTIVE DUTY DEPENDENTS ONLY *(Check One)*
   ☐ (1) RESIDING APART FROM SPONSOR ☐ (2) RESIDING WITH SPONSOR DD FORM 1251 ATTACHED ☐ (3) OUTPATIENT
   ☐ (4) OTHER *(Specify)*

SERVICE MEMBER DATA

7. NAME OF SPONSOR *(last, first, middle initial)*
8. SERVICE NUMBER OR SOCIAL SECURITY NUMBER *(as applicable)*
9. GRADE
10. ORGANIZATION AND DUTY STATION *(Home Port for Ships)* *(Address for Retired)*
11. SPONSOR'S OR RETIREE'S BRANCH OF SERVICE
    ☐ (1) USA ☐ (2) USAF ☐ (3) USMC ☐ (4) USN
    ☐ (5) USCG ☐ (6) USPHS ☐ (7) ESSA
12. STATUS
    ☐ (1) ACTIVE DUTY ☐ (2) RETIRED ☐ (3) DECEASED

13. CERTIFICATION

I certify to the best of my knowledge and belief the above information in Section I is correct. To the extent that I have authority to do so I hereby authorize the release of medical records in this case to both the contractor and the Government.

If a RETIRED MEMBER or dependent of a retired or deceased member, I certify that to the best of my knowledge and belief, that *(Check appropriate box)* *(Delete portion in parenthesis not applicable)*

☐ (I am not) (the patient is not) enrolled (neither is sponsor) in any other insurance, medical service, or health plan provided by law or through employment.

☐ (I am) (the patient is) enrolled (so is sponsor) in another insurance, medical service, or health plan provided by law or through employment, however the particular benefits claimed on this form are not payable under the other plan.

Name (print or type) _____ (Relationship to Patient) _____ Date _____ Signature _____

SECTION II *(To be completed by Source of Care)*

14. NAME AND ADDRESS OF HOSPITAL *(Include Zip Code)*
15. CIVILIAN SOURCE LOCATION CODE
16. THIS STATEMENT CONSTITUTES
    ☐ (1) A COMPLETE BILLING
    OR PARTIAL BILLING *(Check appropriate box)*
    ☐ (2) INITIAL STATEMENT ☐ (3) INTERIM STATEMENT ☐ (4) FINAL STATEMENT
17. HOSPITAL SERVICES
    ☐ (1) INPATIENT ☐ (2) OUTPATIENT
18. DISPOSITION OF PATIENT
    ☐ (1) REMAINING ☐ (2) DISCHARGED ☐ (3) DECEASED
19. INCLUSIVE DATES OF CARE
    FROM — MONTH / DAY / YEAR — TO — MONTH / DAY / YEAR
20. HOSPITAL DAYS THIS STATEMENT
21. NAME OF ATTENDING OR ADMITTING PHYSICIAN OR DENTIST
22. DIAGNOSIS *(Use standard nomenclature)*
    ☐ (1) MENTAL ☐ (2) CHRONIC
23. MTL STAT CLASS
24. ICD-BNPAK CODE
25. PROCEDURE CODE
26. PROCEDURES *(List by date, surgical operation performed)*

33. CERTIFICATION OF SPECIAL CIRCUMSTANCES BY ATTENDING PHYSICIAN OR DENTIST

I certify that *(Complete appropriate space(s))*

a. ☐ Services were necessary for treatment of a bonafide medical emergency.

b. _____ Days PRIVATE ROOM care billed on this claim were required for proper care and treatment of the patient.

c. _____ Days / hours PRIVATE DUTY NURSING CARE billed on this claim were required for proper care and treatment of the patient.

d. ☐ Other (Specify)

DATE AND SIGNATURE OF ATTENDING PHYSICIAN OR DENTIST *(Only when an entry made in item 33)*

34. CERTIFICATION OF SOURCE OF CARE

I certify that

(1) This statement is for services furnished the patient as authorized by the attending physician or dentist.

(2) The amounts claimed in item 28 are true and correct and do not exceed those charged the general public for like services

(3) Except for the amount shown in item 30 payment for these services has not been received.

(4) Except for the amount shown in item 30 no claim for payment for services included in the statement and authorized under the Civilian Health and Medical Program of the Uniformed Services will be made upon the patient or sponsor.

DATE AND SIGNATURE OF CLAIMANT OR AUTHORIZED REPRESENTATIVE OF HOSPITAL

27. RELATED AUTHORIZED ADMISSIONS

DATE ADMITTED TO HOSPITAL	DATE DISCHARGED FROM HOSPITAL	DEDUCTIONS APPLIED
		$

28. AUTHORIZED SERVICES

TYPE	DAYS	RATE	CHARGES
a. ROOM PRIVATE			
b. (Avg-Semi-Private Rate)			
c. ROOM, S-PRIVATE (3, 3, 4 Beds)			
d. ROOM WARD			
e. ROOM NURSERY			
f. OPERATING ROOM			
g. DELIVERY ROOM			
h. ANESTHESIA SERVICES *(By hospital employee)*			
i. LABORATORY SERVICES			
j. X-RAY SERVICES			
k. DRESSING AND CAST SERVICES			
l. DRUGS AND MEDICATION SERVICES			
m. OTHER SERVICES *(Specify)*			
29 TOTAL CHARGES THIS STATEMENT FOR CARE AUTHORIZED			
30 (PAID BY) OR (DUE FROM) PATIENT *(Cross out one)*			
31 DUE FROM GOVERNMENT			
32 VARIANCE (ITEM 29 LESS 30 AND 31)			

The persons signing this form are advised that the willful making of a false or fraudulent statement herein renders them liable to prosecution under applicable Federal Laws

DA FORM 1 JUN 67 1863-2 (Civilian Hospitals) REPLACES DA FORM 1868-1 1 SEP 61 WHICH IS OBSOLETE Form Approved Comptroller General, U. S. 22 Sep 67

EXHIBIT 2-B

SPECIAL INSTRUCTIONS
(Please check form for completeness to eliminate delay in processing)

The sponsor, patient or responsible family member will be required to complete items 1 through 13 of this claim form, and the Source of Care will complete the remainder of the form. The completed claim will then be forwarded to the appropriate fiscal administrator for processing.

SECTION I
INSTRUCTIONS FOR COMPLETION OF ITEMS BY PATIENT

ITEM 5. IDENTIFICATION CARD. If the DD Form 1173 is used, the Effective Date is located on the reverse side of the card in block 15b. The Expiration Date is located on the front side of the card in block 3.

If DD Form 2(Ret) or PHS Form 1866-3(Ret) is used, the Effective Date is located on the reverse side of the card in block entitled DATE OF ISSUE. The Expiration Date is located on the front of the card in the block entitled EXPIRATION DATE.

ITEM 6. BASIS FOR CARE-ACTIVE DUTY DEPENDENTS ONLY

OUTPATIENT CARE - Spouses and children of active duty personnel may elect to obtain OUTPATIENT care from either civilian or uniformed services facilities. (Prenatal and postnatal care are considered part of maternity care.)

INPATIENT CARE - Spouses and children of active duty personnel who reside APART from their sponsor may obtain INPATIENT care from either civilian or uniformed services facilities.

Spouses and children of active duty personnel who reside WITH their sponsor must obtain INPATIENT care including MATERNITY care from uniformed services medical facilities unless the care is provided under emergency conditions or on a trip. If these exceptions do not apply, care from civilian sources at Government expense may be obtained within the United States & Puerto Rico ONLY if a Nonavailability Statement (DD Form 1251), indicating that the required care is not available from a uniformed services medical facility located within a reasonable distance of the patient's residence, is attached to this claim.

DEPENDENT PARENTS AND PARENTS-IN-LAW are NOT authorized civilian medical care at Government expense under any circumstances.

ITEM 8. SERVICE NUMBER OR SOCIAL SECURITY NUMBER. The sponsor's service number or social security number is located in block 12 of the dependent's DD Form 1173.

ITEM 10. ORGANIZATION AND DUTY STATION. Active duty dependents enter the present duty assignment of sponsor. Retired and dependents of retired enter residence of Retiree. Dependents of deceased leave blank.

ITEM 13. CERTIFICATION

If an authorization in addition to that contained in the executed certificate in Item 13 is considered necessary for the release of medical records pertinent to the care furnished, then the source of civilian medical care should obtain the same.

The Law (10 U.S.C. 1086(d)) provides that no benefits under this program may be provided to a retired person or the dependent of a retired or deceased member enrolled in any other insurance, medical service or health plan provided by law or through employment unless that person certifies that the particular benefit he is claiming is not payable under the other plan.

The certificate will be signed by the retiree, dependent receiving care when 18 years of age or over, sponsor or other responsible family member.

SECTION II
INSTRUCTIONS FOR COMPLETION OF ITEMS BY SOURCE OF CARE

ITEM 15. Contractor use only.

ITEM 16. STATEMENT. Check applicable block to reflect appropriate type of statement being submitted.

ITEM 22. DIAGNOSIS. Use standard nomenclature. Also, check applicable block if diagnosis is mental or chronic.

ITEMS 23, 24 and 25. Contractor use only.

ITEM 26. PROCEDURES. Enter all surgical operations performed.

ITEM 27. RELATED AUTHORIZED ADMISSIONS. Enter admission and discharge dates for all periods of hospitalization during period of care (Item 19) covered by this statement.

ITEM 28. AUTHORIZED SERVICES. Enter only information relative to type of service or services authorized under the Civilian Health and Medical Program of the Uniformed Services for which this statement is being submitted.

ITEM 29. TOTAL CHARGES. Enter total of the authorized services furnished, as shown in Item 28.

ITEM 30. PAID BY OR DUE FROM PATIENT. (Enter patient's liability.)

a. Dependents of active duty personnel.

(1) INPATIENT CARE - The first $25.00 of the hospital charges or $1.75 per day, whichever amount is greater. No charge for services of professional personnel.

(2) OUTPATIENT CARE - For authorized outpatient care claimed during a fiscal year (1 July through 30 June) for only one family member, the patient (or sponsor) must pay the first $50.00 of the charges. If benefits are claimed for two or more members of a family group, the patient (or sponsor) must pay the first $100 of the charges. After the deductible has been met, the patient will pay 20% of all charges incurred for authorized outpatient care for the remainder of the fiscal year.

b. Retired personnel and their dependents and dependents of deceased personnel.

(1) INPATIENT CARE - 25% of hospital charges and fees of professional personnel.

(2) OUTPATIENT CARE - The patient or family group will be required to pay the same deductible as is applicable to dependents of active duty personnel. Thereafter, the patient or family group will be required to pay 25% of any expenses incurred for authorized outpatient care for the remainder of the fiscal year.

ITEM 31. DUE FROM GOVERNMENT. Hospitals will enter the amount due from the Government taking into consideration the rate agreements with contractors when such agreements exist.

ITEM 32. VARIANCE. MUST be completed for those hospitals which have rate agreements with contractors.

ITEM 33. CERTIFICATION OF SPECIAL CIRCUMSTANCES.

Enter figures required, or check blocks as appropriate for the patient being treated. To be payable, claims covering authorized care furnished to a hospitalized inpatient in a medical facility which does not meet the definition of "Hospital" under the Program must show that treatment was a bonafide medical emergency by checking the block, Emergency. The block, Other, Specify, will be utilized, with a short specific statement included, when an additional certification not listed is required. The attending physician or dentist must sign the certificate prior to submission of the claim for payment.

ITEM 34. CERTIFICATION OF SOURCE OF CARE.

This certificate must be signed prior to submission of claim for payment.

EXHIBIT 3-A

SERVICES AND/OR SUPPLIES PROVIDED BY CIVILIAN SOURCES (EXCEPT HOSPITALS)

CIVILIAN HEALTH AND MEDICAL PROGRAM OF THE UNIFORMED SERVICES (CHAMPUS)

SEE INSTRUCTIONS ON REVERSE

SECTION I *(To be completed by patient or other responsible family member. Please print or type)*

PATIENT DATA		SERVICE MEMBER DATA		
1. NAME *(last, first, middle initial)*	2. DATE OF BIRTH	7. NAME OF SPONSOR *(last, first, middle initial)*		
3. ADDRESS *(Include Zip Code)*		8a. SERVICE NUMBER	b. SOCIAL SECURITY ACCOUNT NUMBER	9. GRADE
		10. ORGANIZATION AND DUTY STATION *(Home Port for Ships) (Address for Retired)*		
4. PATIENT IS A *(Check one)* ☐(1) SPOUSE ☐(2) DAUGHTER ☐(3) SON ☐(4) RETIREE				
5. IDENTIFICATION CARD *(DD Form 1173, DD Form 2 or PHS Form 1066—3)* CARD NO. EFFECTIVE DATE (MONTH DAY YEAR) EXPIRATION DATE		11. SPONSOR'S OR RETIREE'S BRANCH OF SERVICE ☐(1) USA ☐(2) USAF ☐(3) USMC ☐(4) USN ☐(5) USCG ☐(6) USPHS ☐(7) ESSA		
6. BASIS FOR CARE - ACTIVE DUTY DEPENDENTS ONLY *(Check one)* ☐(1) RESIDING APART FROM SPONSOR ☐(2) RESIDING WITH SPONSOR DD FORM 1251 ATTACHED ☐(3) OUTPATIENT ☐(4) OTHER *(Specify)*		12. STATUS ☐(1) ACTIVE DUTY ☐(2) RETIRED ☐(3) DECEASED		

13. CERTIFICATION

I certify to the best of my knowledge and belief the above information in Section I is correct. To the extent that I have authority to do so I hereby authorize the release of medical records in this case to both the contractor and the Government.
If a RETIRED MEMBER or dependent of a retired or deceased member, I certify that to the best of my knowledge and belief, that *(Check appropriate box) (Delete portion in parenthesis not applicable)*

☐ (I am not) (the patient is not) enrolled (neither is sponsor) in any other insurance, medical service, or health plan provided by law or through employment.

☐ (I am) (the patient is) enrolled (so is sponsor) in another insurance, medical service, or health plan provided by law or through employment; however the particular benefits claimed on this form are not payable under the other plan.

Name (print or type) | (Relationship to Patient) | Date | Signature

SECTION II *(To be completed by Source of Care)*

14. NAME AND ADDRESS OF SOURCE OF CARE *(Include Zip Code)*	a. SOURCE OF CARE LOCATION CODE	b. PROVIDER OF SERVICES ☐(1) ATTENDING PHYSICIAN ☐(2) OTHER *(Specify)*
		c. PATIENT STATUS ☐(1) INPATIENT ☐(2) OUTPATIENT
15. NAME AND TITLE OF INDIVIDUAL ORDERING CARE	16. INCLUSIVE DATES OF CARE FROM (MONTH DAY YEAR) TO (MONTH DAY YEAR)	
17. DIAGNOSIS *(Use standard nomenclature)* (Check when applicable) ☐ services were necessary for treatment of a bonafide medical emergency	a. INTL. STAT. CODE b. 12 - BREAK CODE	
18. RELATED HOSPITALIZATION *(If applicable)* FROM TO		

19. ENTER ESTIMATED OR ACTUAL DATE OF DELIVERY IN MATERNITY CASES. LIST BY DATE SURGICAL OPERATIONS AND/OR CARE FURNISHED INCLUDING VISITS FOR WHICH SEPARATE CHARGES ARE CLAIMED *(Type or print)* *(Attach additional sheets if required)*

DATE(S) OF SERVICE	a. ITEM OR DESCRIPTION OF SERVICE	b. CHARGES	c. PROCEDURE CODE
		$	
d. TOTAL CHARGES THIS STATEMENT FOR CARE AUTHORIZED		$	
e. (PAID BY) OR (DUE FROM) PATIENT *(Cross out one)*		$	
f. DUE FROM GOVERNMENT TO SOURCE OF CARE		$	
g. DUE PATIENT OR SPONSOR, REIMBURSEMENT		$	

20. CERTIFICATION BY SOURCE OF CARE

I certify that the services and / or supplies listed hereon were performed or authorized by the attending physician, dentist or other professional personnel in charge, that payment due from the Government has not been received, and that, except for the amount payable by the patient in accordance with the terms of the Civilian Health and Medical Program of the Uniformed Services, the amount paid by the Government will be accepted as payment in full for the authorized services and / or supplies listed hereon.
I further certify that I am not an intern, resident or otherwise in training status for which I am receiving compensation for services listed on this claim.

Name (print or type) | Title | Date | Signature

The person signing this form are advised that the willful making of a false or fraudulent statement herein renders them liable to prosecution under applicable Federal Laws

DA FORM 1 JUN 67 1863 – 2 (Civilian Sources) REPLACES DA FORM 1863-2, 1 SEP 61, WHICH IS OBSOLETE. Form Approved Comptroller General, U. S., 22 Sep 67

EXHIBIT 3-B

SPECIAL INSTRUCTIONS
(please check form for completeness to eliminate delay in processing)

This form will be used by all civilian sources of care other than hospitals, pharmaceutical services in the United States and Puerto Rico, and sources providing care under the Handicapped Program.

The sponsor, patient or responsible family member will be required to complete Items 1 through 13 of this claim form, and the source of care will complete the remainder of the form. The completed claim will then be forwarded to the appropriate fiscal administrator for processing.

SECTION I
INSTRUCTIONS FOR COMPLETION OF ITEMS BY PATIENT

ITEM 5. IDENTIFICATION CARD. If the DD Form 1173 is used, the Effective Date is located on the reverse side of the card in block 15b. The Expiration Date is located on the front side of the card in block 3.

If DD Form 2(Ret) or PHS Form 1866-3(Ret) is used, the Effective Date is located on the reverse side of the card in block entitled DATE OF ISSUE. The Expiration Date is located on the front of the card in the block entitled EXPIRATION DATE.

ITEM 6. BASIS FOR CARE-ACTIVE DUTY DEPENDENTS ONLY

OUTPATIENT CARE-Spouses and children of active duty personnel may elect to obtain OUTPATIENT care from either civilian or uniformed services facilities. (Prenatal and postnatal care are considered part of maternity care.)

INPATIENT CARE-Spouses and children of active duty personnel who reside APART from their sponsor may obtain INPATIENT care from either civilian or uniformed services facilities.

Spouses and children of active duty personnel who reside WITH their sponsor must obtain INPATIENT care including MATERNITY care from uniformed services medical facilities unless the care is provided under emergency conditions or on a trip. If these exceptions do not apply, care from civilian sources at Government expense may be obtained within the United States & Puerto Rico ONLY if a Nonavailability Statement (DD Form 1251), indicating that the required care is not available from a uniformed services medical facility located within a reasonable distance of the patient's residence, is attached to this claim.

DEPENDENT PARENTS AND PARENTS-IN-LAW are NOT authorized civilian medical care at Government expense under any circumstances.

ITEM 8a. SERVICE NUMBER. b. SOCIAL SECURITY ACCOUNT NUMBER. Enter the sponsor's service number *(located in block 12 of the dependent's DD Form 1173)*, and sponsor's social security account number.

ITEM 10. ORGANIZATION AND DUTY STATION. Active duty dependents enter the present assignment of sponsor. Retired and dependents of retired enter residence of Retiree. Dependents of deceased leave blank.

ITEM 13. CERTIFICATION

If an authorization in addition to that contained in the executed certificate in Item 13 is considered necessary for the release of medical records pertinent to the care furnished, then the source of civilian medical care should obtain the same.

The Law (10 U.S.C. 1086(d)) provides that no benefits under this program may be provided to a retired person or the dependent of a retired or deceased member enrolled in any other insurance, medical service or health plan provided by law or through employment unless that person certifies that the particular benefit he is claiming is not payable under the other plan.

The certificate will be signed by the retiree, dependent receiving care when 18 years of age or over, sponsor or other responsible family member.

SECTION II
INSTRUCTIONS FOR COMPLETION OF ITEMS BY SOURCE OF CARE
(Shaded areas are for CONTRACTOR USE ONLY)

ITEM 15. NAME & TITLE OF INDIVIDUAL ORDERING CARE. Individual ordering *care* must be the attending physician, dentist or other professional *person* in charge.

ITEM 17. DIAGNOSIS. EMERGENCY-This block will be checked only when a bonafide medical emergency exists.

ITEM 18. RELATED HOSPITALIZATION. Enter the inclusive dates of related hospitalization if applicable.

ITEM 19a, b and c. Enter only those services and/or supplies which are authorized for payment under CHAMPUS. All services and supplies should be itemized to insure prompt and proper payment. Payment by the Government to the source of services and supplies is based normally upon usual, customary, and reasonable charges. However, should a physician, dentist, or other professional person expend unusual effort for proper care of the patient, he should submit a clinical summary with his claim in support of a request for special consideration of the amount payable for his services.

d. Enter total of the authorized charges in Column 19b.

e. Enter the patient's liability.

(1) Dependents of active duty personnel.

(a) Outpatient Care. For authorized outpatient care claimed during a fiscal year (1 July through 30 June) for only one family member, the patient (or sponsor) shall be required to pay the first $50.00 of the charges. If benefits are claimed for two or more members of a family group, the patient (or sponsor) must pay the first $100.00 of the charges. After the deductible has been met, the patient (or sponsor) will pay 20% of all charges incurred for authorized outpatient care for the remainder of the fiscal year. The Government's share of the cost of benefits after the deductible has been met will be 80%.

(b) Inpatient Care. No charge for professional services.

(2) Retired personnel and their dependents and the dependents of deceased personnel.

(a) Outpatient Care. The patient or family group will be required to pay the same deductible as is applicable to dependents of active duty personnel. Thereafter the patient or family group will be required to pay 25% of any expenses incurred for authorized outpatient care for the remainder of the fiscal year. The Government's share of the cost of benefits provided after the deductible has been met will be 75%.

(b) Inpatient Care. The patient (or sponsor) shall be required to pay 25% of the fees of professional personnel for authorized inpatient care. The Government's share of the cost will be 75% of the total charge for authorized inpatient care.

ITEM 20. CERTIFICATION BY SOURCE OF CARE. The Program operates under the full payment concept which means that, except for the amount payable by the patient, the amount paid by the Government to the source of services and/or supplies shall constitute payment in full for the authorized care, and no further amount will then be due from any source for those same services or supplies. Therefore, it is necessary that the certification in Item 20 be completed without alteration. In the event this is not done, payment from public funds to the source of care will not be made.

EXHIBIT 4-A

SEE INSTRUCTIONS ON REVERSE	SERVICES AND/OR SUPPLIES - HANDICAPPED PROGRAM (ACTIVE DUTY DEPENDENTS ONLY) CIVILIAN HEALTH AND MEDICAL PROGRAM OF THE UNIFORMED SERVICES (CHAMPUS) For use of this form, see AR 40-121; the proponent agency is Office of The Surgeon General.	CASE NUMBER

SECTION I *(To be completed by patient or other requestor. Use separate sheet for each patient. Please print or type)*

PATIENT DATA

1 NAME *(Last, first, middle initial)*

2 DATE OF BIRTH

3 ADDRESS *(Include Zip Code)*

4 PATIENT IS A *(Check one)*
☐ (1) SPOUSE ☐ (2) DAUGHTER ☐ (3) SON

5 IDENTIFICATION CARD *(DD Form 1173)*
CARD NO
EFFECTIVE DATE / EXPIRATION DATE — MONTH / DAY / YEAR

SERVICE MEMBER DATA

6 NAME OF SPONSOR *(Last, first, middle initial)*

7a SERVICE NUMBER

7b SOCIAL SECURITY ACCOUNT NUMBER

8 PAY GRADE

9 ORGANIZATION AND DUTY STATION *(Home Port for Ships)*

10 SPONSOR'S BRANCH OF SERVICE
☐ (1) USA ☐ (2) USAF ☐ (3) USMC ☐ (4) USN
☐ (5) USCG ☐ (6) USPHS ☐ (7) ESSA

11 CERTIFICATION

I certify to the best of my knowledge and belief the above information in Section I is correct. The handicapped case has been accepted by OCHAMPUS or appropriate overseas commander. To the extent that I have authority to do so I hereby authorize the release of medical records in this case to both the contractor and the Government

Name (print or type) | Relationship to Patient | Date | Signature

SECTION II *(To be completed by Source of Care)*

12 NAME AND ADDRESS OF SOURCE OF CARE *(Include Zip Code)*

a SOURCE OF CARE LOCATION CODE

c. TYPE OF CARE
☐ (1) HOSPITAL ☐ (2) INSTITUTION
☐ (2) OUTPATIENT

b TYPE OF FACILITY
☐ (1) PUBLIC OR STATE
☐ (2) PRIVATE NON PROFIT
☐ (3) PRIVATE PROFIT

13 NAME AND TITLE OF INDIVIDUAL ORDERING CARE

14 DIAGNOSIS *(Use standard nomenclature)*

a 13 DIGIT CODE

b PRIMARY CODE

c INCLUSIVE DATE OF CARE
FROM | TO

15 DATES OF SERVICE	a ITEM OR DESCRIPTION OF SERVICE	b CHARGES	c PROCEDURE CODE
		$	
a TOTAL CHARGES THIS STATEMENT FOR CARE AUTHORIZED		$	
e (PAID BY) OR (DUE FROM) PATIENT *(Cross out one)*		$	
f DUE FROM GOVERNMENT TO SOURCE OF CARE		$	
g DUE PATIENT OR SPONSOR REIMBURSEMENT		$	

16 CERTIFICATION BY SOURCE OF CARE

I certify that the services and/or supplies listed hereon were performed or authorized by the attending physican, dentist or other professional personnel in charge, that payment due from the Government has not been received and that, except for the amount payable by the patient in accordance with the terms of the Civilian Health and Medical Program of the Uniformed Services, the amount paid by the Government will be accepted as payment in full for the authorized services and /or supplies listed hereon.

I further certify that I am not an intern, resident or otherwise in training status for which I am receiving compensation for services listed on this claim.

Name (print or type) | Title | Date | Signature

The purpose server this form are advised that the wilful making of a false or fraudulent statement herein renders them liable to prosecution under applicable Federal Laws

17. FISCAL ADMINISTRATOR USE ONLY

DA FORM 1 JUN 67 1863 3 (Handicapped) Form Approved Comptroller General U.S., 23 Sep 67

EXHIBIT 4-B

SPECIAL INSTRUCTIONS

(Please check form for completeness to eliminate delay in processing)

This form is for submission of claims by all sources of service and ca supplies, which pertain ONLY to the Handicapped portion of the Civilian Health and Medical Program of the Uniformed Services.

No benefits are payable under the Handicapped Program unless the Executive Director, OCHAMPUS, or appropriate overseas commander has accepted the dependent for benefits under the program and approved a plan for management of the handicapping condition. At the time of acceptance of the dependent in the program and approval of benefits, a case number is assigned and claim forms provided the sponsor or other responsible family member who must complete Items 1 through 11. The source of care will complete the remainder of the form. The completed claim form will then be forwarded to the appropriate fiscal administrator for processing.

SECTION I
INSTRUCTIONS FOR COMPLETION OF ITEMS BY SPONSOR OR OTHER RESPONSIBLE FAMILY MEMBER

ITEM 5. IDENTIFICATION CARD. The EFFECTIVE DATE is located on the reverse side of DD Form 1173 in block 15b. The EXPIRATION DATE is located on the front side of DD Form 1173 in block 3.

ITEM 7a SERVICE NUMBER 7b. SOCIAL SECURITY ACCOUNT NUMBER Enter sponsor's service number (located in block 12 of Dependent's DD Form 1173) in 7a and sponsor's social security account number in 7b

ITEM 8. PAY GRADE Enter appropriate pay grade, E-1, W-1, O-1, etc. (See chart below)

ITEM 9. ORGANIZATION AND DUTY STATION. Enter the present duty assignment of sponsor.

ITEM 11. CERTIFICATION

This certificate MUST be signed prior to submission of the claim for payment. It will be signed by the dependent receiving care when 18 years of age or over, by the sponsor, or other responsible family member. If an authorization, in addition to that contained in the executed certificate in Item 11, is considered necessary for the release of medical records pertinent to the care furnished to the dependent, then the source of civilian medical care should obtain the same.

SECTION II
INSTRUCTIONS FOR COMPLETION OF ITEMS BY SOURCE OF CARE

ITEM 12c. TYPE OF CARE. Hospital–for any service or supply provided while in an inpatient status (patient entered on the roll of the hospital as an inpatient.)

Institution–care provided in private nonprofit, public or state institutions and facilities. Normally, this is residential care.

Outpatient–services provided on a visit basis in the home, hospital, clinic, institution, agency or office by professional persons.

ITEM 13. NAME & TITLE OF INDIVIDUAL ORDERING CARE. Individual ordering care must be the attending physician, dentist, or other professional person in charge.

ITEM 14. DIAGNOSIS. Only moderately or severely mentally retarded and seriously physically handicapped spouses and children of ACTIVE DUTY members may receive care under the handicapped portion of the CHAMPUS. Therefore, the diagnosis of these patients must reflect the degree of impairment. Further, original diagnosis of such conditions must be made by a physician.

c. Inclusive dates of care covered by this claim.

ITEM 15 a, b, and c. Enter only those services and/or supplies which are authorized for payment under the CHAMPUS. All services and/or supplies should be itemized to insure prompt and proper payment.

d. Enter total of the authorized charges in column 15b.

e. Enter the patient's (Sponsor's) liability, which is limited to:

If the cost of services provided his dependent under the Handicapped Program in a particular month is less than the amount prescribed for his pay grade, (see chart) the entire cost must be paid by the service member. When the cost per month exceeds the amount shown for his pay grade, he shall be required to pay the amount shown for his pay grade plus the amount, if any, by which the total charge exceeds his payment and the Government's maximum payment of $350.00.

f. The Government's share of the cost of benefits provided a particular dependent under the handicapped program shall not exceed $350.00 per month except in cases of multiple dependents incurring expenses.

ITEM 16. CERTIFICATION BY SOURCE OF CARE. This certificate must be signed prior to submission of claim for payment.

AMOUNT	PAY GRADE	ARMY	MARINE CORPS	COAST GUARD/NAVY	AIR FORCE
$ 45	E–9	Sergeant major	Sergeant major Master gunnery sergeant	Master chief petty officer	Chief master sergeant
40	E–8	First sergeant Master sergeant	First sergeant Master sergeant	Senior chief petty officer	Senior master sergeant
35	E–7	Platoon sergeant Sergeant first class Master sergeant [1] Specialist Seven	Acting master sergeant [2] Gunnery sergeant	Chief petty officer	Master sergeant
30	E–6	Staff sergeant Sergeant first class [1] Specialist Six	Acting gunnery sergeant [2] Staff sergeant	Petty officer first class	Technical sergeant
25	E–5	Sergeant Specialist Five	Acting staff sergeant [2] Sergeant	Petty officer second class	Staff sergeant
25	E–4	Corporal Specialist Four	Acting sergeant [2] Corporal	Petty officer third class	Airman first class
25	E–3	Private first class	Acting corporal [2] Lance corporal	Seaman	Airman second class
25	E–2	Private	Private first class	Seaman apprentice	Airman third class
25	E–1	Private	Private	Seaman recruit	Airman, basic

[1] Transitional title for those who held this grade continuously since 31 May 1958.

[2] Transitional title for those holding pay grade 31 December 1958

AMOUNT	PAY GRADE	ARMY, AIR FORCE, and MARINE CORPS	COAST GUARD, NAVY and ESSA
$250	O–10	General	Admiral
200	O–9	Lieutenant general	Vice admiral
150	O–8	Major general	Rear admiral (upper half)
100	O–7	Brigadier general	Rear admiral (lower half)
75	O–6	Colonel	Captain
65	O–5	Lieutenant colonel	Commander
50	O–4	Major	Lieutenant commander
45	O–3	Captain	Lieutenant
40	O–2	First lieutenant	Lieutenant (junior grade)
35	O–1	Second lieutenant	Ensign

AMOUNT	PAY GRADE	WARRANT OFFICERS
$50	W–4	Chief warrant officer, W–4
50	W–3	Chief warrant officer, W–3
45	W–2	Chief warrant officer, W–2
45	W–1	Warrant officer, W–1

NOTE: Because of the numerous grade titles of the personnel in the commissioned corps of the Public Health Service, they have not been listed on this form.

EXHIBIT 5

PRESCRIPTION BILLING – OUTPATIENT PHARMACEUTICAL SERVICES – CIVILIAN HEALTH AND MEDICAL PROGRAM OF THE UNIFORMED SERVICES — *SEE INSTRUCTIONS ON FRONT FLAP*

SECTION I – PATIENT AND SPONSOR DATA

1. PATIENT'S NAME AND ADDRESS *(Include Zip Code)*

2. DATE OF BIRTH

3. PATIENT IS ☐ (1) SPOUSE ☐ (2) DAUGHTER ☐ (3) SON ☐ (4) RETIREE

4. IDENTIFICATION CARD *(DD Form 1173, DD Form 2, or PHS Form 1066–3)*
CARD NUMBER
EFFECTIVE DATE — MONTH / DAY / YEAR
EXPIRATION DATE

5. SPONSOR'S NAME *(Last, First, Middle Initial)*

6a. SERVICE NUMBER

6b. SOCIAL SECURITY ACCOUNT NUMBER

7. STATUS ☐ (1) ACTIVE DUTY ☐ (2) RETIRED ☐ (3) DECEASED

8. BRANCH OF SERVICE ☐ (1) USA ☐ (2) USAF ☐ (3) USMC ☐ (4) USN ☐ (5) USCG ☐ (6) USPHS ☐ (7) USESSA

9. CERTIFICATION OF PATIENT OR SPONSOR. I certify that the above information is correct; that I have received the material and service described hereon and I authorize the release of any information pertaining to this service to both the Contractor and the Government. If a RETIRED MEMBER, or a dependent of a retired or deceased member, I certify that to the best of my knowledge and belief that *(Check applicable box and delete portion in parenthesis that is not applicable)*

☐ (I am not) (the patient is not) enrolled (neither is sponsor) in any other insurance, medical service or health plan provided by law or through employment.

☐ (I am) (the patient is) enrolled (so is sponsor) in another insurance, medical service or health plan provided by law or through employment; however the particular benefits claimed on this form are not payable under the other plan.

NAME *(Print or Type)* — DATE — RELATIONSHIP TO PATIENT — SIGNATURE

SECTION II – VENDOR PHARMACY DATA

10. PRESCRIPTION NUMBER	10. PRESCRIPTION DATE FILLED	11. MEDICATION NAME, STRENGTH, DOSAGE FORM	12. QUANTITY	13. NEW OR REFILL	14. ACQUISITION COST	15. PROFESSIONAL FEE	16. TOTAL *(Items 14 plus 15)*	17. (PAID BY) OR (DUE FROM) PATIENT	18. DUE FROM GOVERNMENT	FOR USE BY FISCAL ADMINISTRATOR		

19. OUTPATIENT DEDUCTIBLE CERTIFICATE *(Enter State and Expiration Date)*

20. PHARMACY CODE

21. NAME AND ADDRESS OF PHARMACY *(Include Zip Code)*

22. CERTIFICATION OF PHARMACIST. I certify that I have furnished the medication and services described hereon and that the information is correct to the best of my knowledge. Except for the amount payable by the patient in accordance with terms of the Civilian Health and Medical Program of the Uniformed Services, the amount paid by the Government will be accepted as payment in full for the authorized services and/or supplies listed hereon.

SIGNATURE OF PHARMACIST AND DATE

DA FORM 1863-4, 1 Jun 69

☆ U. S. GOVERNMENT PRINTING OFFICE: 1969 — 358-296

correct and the co-insurance declaration statement. This last statement is especially important if the beneficiary is a retired member or his dependent.

Upon completion of treatment the remainder of the form is filled out by the provider and submitted to one of the fiscal administrators or hospital contractors listed on Exhibit 6. In many cases, either because of the policies of the provider or the desires of the sponsor/patient, the patient will pay the provider for the full cost of the treatment and then submit a claim for reimbursement. The actual recipient of the claim depends on the geographic area where the treatment was provided. For example, in California all inpatient claims are submitted to either Blue Cross of Northern California or Blue Cross of Southern California. All claims in the state from physicians and other non-hospital type providers are submitted to Blue Shield of California. Dental claims for California and all other states are sent to the Colorado Dental Service, Denver, Colorado, while claims from Christian Scientist practitioners are submitted to Massachusetts Blue Cross, Boston, Massachusetts.

The claims processing procedures used by the various fiscal administrators and hospital contractors are fully described in the CHAMPUS Program Manual issued by OCHAMPUS. Since the inputs and required outputs are standardized, it will be assumed that each of these agencies follows a somewhat similar claims processing procedure. The systems described in the

EXHIBIT 6

CHAMPUS FISCAL ADMINISTRATORS AND HOSPITAL CONTRACTORS

Alabama - Mutual of Omaha (BC)
Alaska - Blue Cross, Washington-Alaska, Inc. (BC)
Arizona - Blue Shield Medical Services (BC)
Arkansas - Blue Cross-Blue Shield, Inc. (M)
California - Blue Shield of California (BC)
Canada - Mutual of Omaha (M)
Colorado - Medical Service Inc. (BC)
Connecticut - Connecticut General Life Insurance Co. (BC)
Delaware - Blue Cross and Blue Shield of Delaware, Inc. (BC)
District of Columbia - Medical Service of District of Columbia (includes all of Washington, D. C., and contiguous counties and cities of Maryland and Virginia) (BC)
Florida - Blue Shield of Florda, Inc. (M)
Georgia - Medical Association of Georgia (M)
Hawaii - Medical Service Association (BC)
Idaho - North Idaho District Medical Service (BC)
Illinois - Mutual of Omaha (M)
Indiana - Indiana State Medical Association (M)
Iowa - Iowa Medical Service (M)
Kansas - Kansas Blue Shield (M)
Kentucky - Physician's Mutual Inc. (BC)
Louisiana - Continental Life and Health Ins. Co. (M)
Maine - Associated Hospital Service of Maine (BC)
Maryland - Maryland Blue Shield (except areas near Washington, D.C.) (BC)
Massachusetts - Blue Shield Inc. and Massachusetts Blue Cross (BC)
Mexico - Mutual of Omaha (M)
Michigan - Michigan Medical Service (BC)
Minnesota - Minnesota Medical Service, Inc. (M)
Mississippi - Mississippi State Medical Association (BC)
Missouri - Missouri Medical Service (M)
Montana - Montana Physicians Service (BC)
Nebraska - Nebraska Medical Service (M)
Nevada - Nevada State Medical Association (BC)
New Hampshire - Vermont Physician Service (BC)
New Jersey - Medical-Surgical Plan of New Jersey (BC)
New Mexico - Surgical Service Inc., of New Mexico (BC)
New York - United Medical Service, Inc. (BC)
North Carolina - North Carolina Blue Cross and Blue Shield, Inc. (BC)
North Dakota - Blue Shield of North Dakota (M)
Ohio - Mutual of Omaha (M)
Oklahoma - Oklahoma Physicians Service (M)
Oregon - Oregon Physicians Service (BC)

EXHIBIT 6 (CONTINUED)

Pennsylvania - Medical Service Association of Pennsylvania (BC)
Puerto Rico - Mutual of Omaha (BC)
Rhode Island - Mutual of Omaha (BC)
South Carolina - Mutual of Omaha (M)
South Dakota - South Dakota Medical Service, Inc. (M)
Tennessee - Blue Cross and Blue Shield of Tennessee (BC)
Texas - Mutual of Omaha (M)
Utah - Blue Shield of Utah (BC)
Vermont - Vermont Physician Service (BC)
Virginia - Blue Shield of Virginia (except areas near Washington, D. C.) (BC)
Washington - Blue Cross of Washington-Alaska, Inc. (BC)
West Virginia - Medical Surgical Care, Inc. (BC)
Wisconsin - Wisconsin Physicians Service (M)
Wyoming - Wyoming Medical Service, Inc. (BC)

All Dental Claims - Colorado Dental Service
All Christian Scientist Claims - Massachusetts Blue Shield, Inc.

NOTE: Hospital contractors are indicated in the above list by letters in parenthesis: (M) denotes Mutual of Omaha and (BC) denotes Blue Cross Association.

following sections can thus be considered as a representative example of the claims processing systems utilized by the CHAMPUS contractors.

A. BLUE CROSS ASSOCIATION

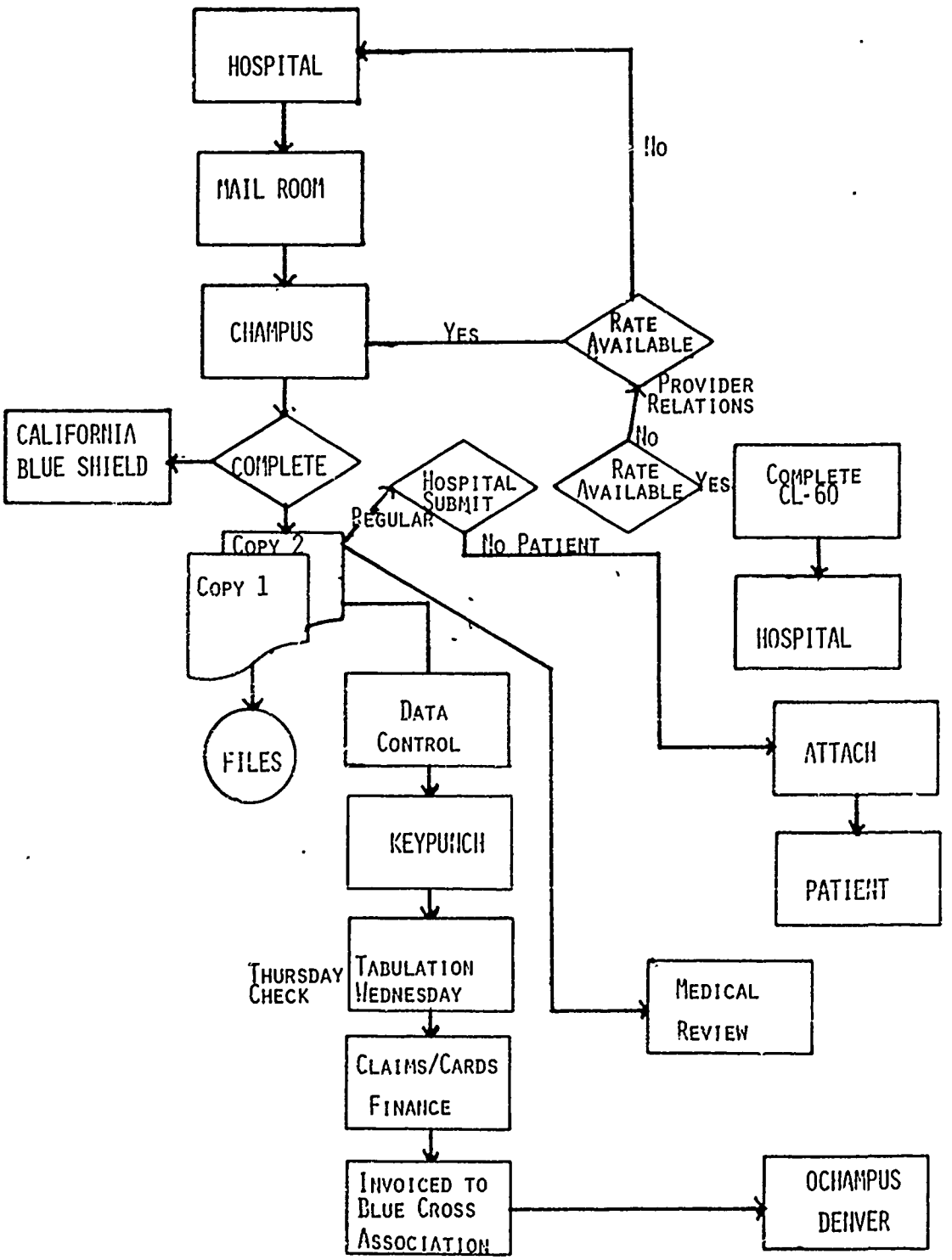
As noted in Exhibit 6, the Blue Cross Association is the primary hospital contractor for inpatient care in thirty-three geographic locations. Each geographic location's Blue Cross organization acts as a subcontractor to process CHAMPUS claims. Blue Cross of Northern California, located in Oakland, California, is typical of these subcontractors. Its area of responsibility is all of Northern California, that is, all of California North of an imaginary line drawn across the state just to the North of Los Angeles County [Ref. 61].

Blue Cross receives approximately 905 inpatient claims per week. The average turnaround time for CHAMPUS claims, from the time the claim is received until the payment check goes into the mail, is seven to eight days. Exhibit 7 depicts the general flow of the claims processing system used by Blue Cross of Northern California. Information concerning the rate structures and the process concerning the "CL-60" is considered confidential information and, as such, was not made available. About 25 percent of all claims cannot be processed on the first submission due to errors and incompletions. The most common errors experienced by Blue Cross are:

1. Errors in dependent identification care information.

EXHIBIT 7

CHAMPUS PROCESSING SYSTEM
CHAMPUS CLAIM, DA-1863-1



2. Physician's name illegible, missing, or is not on their list of qualified hospital staff members.

3. Item thirteen, Other Insurance, was not marked to indicate whether other forms of health insurance were owned by the patient.

4. The diagnosis, as listed, was incomplete or of a questionable nature.

5. A non-availability statement was not attached to the submitted claim.

Upon receipt, all claims are date stamped in their Mail Room. They are then given to processors and are entered into the processing system. Each processor reviews items one through thirty-four (See Exhibit 2) to make certain that the claim is complete. They also review and determine benefit and patient eligibility. If the claim is incomplete, or if it is determined that a review of the diagnosis is needed, the claim would be returned to the provider or forwarded to Medical Review. In the former instance the provider hospital completes the missing information or corrects the errors and resubmits the claim to Blue Cross. In the latter instance a member of Medical Review makes a determination of the diagnosis as being eligible or not eligible as a benefit of the CHAMPUS Program. The claim is then either returned to the provider or re-entered into the processing system. It should be noted that these reviews are for patient and benefit eligibility only. If it is determined that a diagnosis is

not properly a benefit, the liability for payment of the claim falls back upon the patient. This particular feature of the CHAMPUS Program is true if the determination is made as either part of the processor review, a Medical Review, or an OCHAMPUS review.

The second review, accomplished by other than the person doing the first review, is for quality control. In this review, every item on the form is looked at for correctness. If an error is found, the claim is returned to the first processor for action in obtaining the correct information. If no errors are found, the claims are separated, i.e., originals from carbons. The processor then reviews the carbon copies to make certain all entries are correct and readable.

The third and final review is a recheck of the entire claim by a third person for completeness and correctness. Once this review is accomplished, an adding machine tape is prepared for the originals and the carbons. The tapes are compared, and if they are in agreement, the carbon copies and their adding machine tapes are sent to Data Control for keying into the computer system for further processing procedures. Details concerning the computer processing system used by Blue Cross were not made available for this study.

It was learned, however, that if there is a problem concerning charges, the problem would be resolved by persons in the Blue Cross CHAMPUS Department, their Provider Relations Department, and the provider's representatives prior to the

payment of the claim. Upon completion of processing procedures, a batch invoice is sent to the Blue Cross Association in Chicago, Illinois. This invoice, which is sent by telegraphic wire, is prepared on a weekly basis. Each invoice states the amount of claims that Blue Cross of Northern California expects to process in that week. The Blue Cross Association responds by sending Blue Cross of Northern California, and all other Blue Cross Associations, a check for the invoiced amount plus or minus a figure which represents adjustments based on the past week's actual claims processing actions. The Blue Cross Association then invoices a composite amount for all their subcontractors claims processing actions to OCHAMPUS for reimbursement. The OCHAMPUS reimbursement process will be discussed in the following chapter.

B. MUTUAL OF OMAHA INSURANCE COMPANY

The other major hospital contractor is the Mutual of Omaha Insurance Company headquartered in Omaha, Nebraska [Ref. 62]. They handle CHAMPUS hospital claims for nineteen geographic areas. This company is also a fiscal administrator for non-hospital type claims, except for dental and Christian Scientist claims. They are responsible for processing the outpatient type of claim for nine geographic areas (See Exhibit 6). Unlike the Blue Cross Association, they do not use a subcontractor system but rather process all claims in one central office. This is evidenced by the fact that they receive, on a weekly average, about 4,600 CHAMPUS hospital type claims

and more than 10,000 non-hospital type claims. Claims for drugs and durable equipment make up approximately 7.5 percent of the latter figure.

Mutual of Omaha employs a fully integrated, dedicated computer system for its claims processing. Exhibit 8, a simplified flow chart, provides an idea of the claims processing procedures that are followed in utilizing this on-line computer system. The system is composed of an IBM 145 dedicated computer utilizing IBM disc packs and high speed tape drives. Auditor interface with the computer is accomplished through Bunker-Ramo cathode ray tubes and control units. As much of the processing as could be possibly delegated to computer action has been built into this system.

The on-line system permits Mutual of Omaha to process all CHAMPUS claims in 24 hours. All claims that are entered into the system on a given day go through a batch cycle that night. The issued checks are ready for processing and mailing the next morning. Claims requiring extensive audit activity, medical review, or additional information may be held in the system for up to 30 days. Automatic review points have been established in the system so that requests for additional information are followed-up in 45 days if no response has been received by that time.

Like Blue Cross of Northern California, Mutual of Omaha has found that about 25 per cent of its claims have clerical errors. Of these, about 70 percent need clarification of or

EXHIBIT 8

NARRATIVE OF CHAMPUS CLAIMS PROCESSING

Incoming mail is sorted and given to preliminary audit by date stamped in. Returns* by-pass prelim and go directly to the audit activity file.

Prelim inputs claims by date in. Claim #** is assigned at this point by the computer. Providers are added to the file at this point also.

Prelimed claims are added into audit activity file by clai · # order. Returned claims are always handled first each day.

Audited claims are batch processed each night. Those claims that do not meet the batch edits are recycled the next day. Checks are generated on payments. EOB's are prepared and return letters are written.

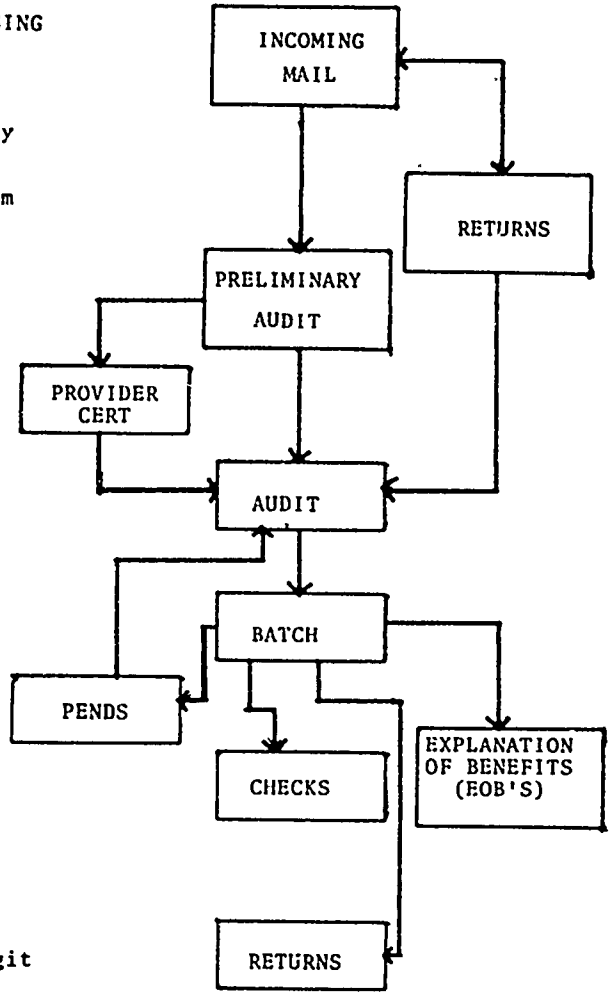
The processed claims are matched to batch output the day following the batch cycle.

Verified payments are mailed as are the EOB's and those claims that must be returned. Claims that are paid or rejected are labled and filed by claim #. Returned claims are held in a pending file.

*Returns are those claims found to be incomplete and not processable. They are returned to sender with a request for the specific items needed. Return letters are computer generated.

**The claim number is composed of a digit for year, 3 digits for Julian day, 5 digits for sequence and a two-place alpha numeric suffix: 3 004 01234-A1.

EOB - Explanation of benefits Statement.



have errors in patient eligibility. That is, clarification in the relationship of the patient to the sponsor, the identification card number, or the beginning or expiration date of eligibility is needed.

Mutual's claims rejection rate is less than one percent. Claims are usually rejected either because care was rendered prior to the beginning eligibility date as shown on the claim form or after the expiration date of the patient's identification card as shown on the claim form. These reasons for rejection account for about 75 percent of all rejections, the remaining rejections caused primarily by the reason that the care provided was not a benefit under CHAMPUS regulations.

In the processing of inpatient claims each claim receives a series of reviews similar to those used by the Blue Cross organization. Itemization on the face of the claim is summarized to determine correctness of the totals. Dates of care must correspond to the number of days being billed and the charge per day must meet the provider's record of room charges supplied to Mutual and recorded in the computer. Ancillary services provided by the hospital are reviewed on the basis of "reasonableness" of the charges for the services rendered. All hospital claims are processed on the basis of billed charges. The patient's deductible is computed based on the length of stay for active duty dependents and on the basis of the patient's co-insurance requirement for retired beneficiaries. This co-insurance feature is a term used by

Mutual to account for the requirement that retired persons must pay 25 percent of all charges for the care that they receive.

The same basic processing system is used for processing non-hospital type claims. Mutual determines whether a physician's charge is his customary charge for similar services and that this customary charge does not exceed the prevailing charge in the locality for similar services. Profiles are maintained on all CHAMPUS physicians and these are periodically reviewed. Once a year the pricing file mechanism is updated to include the most current information on physicians is in Mutual's contract territory.

In the actual claims processing procedure, Mutual's system is on a filtration type. All claims pass through the audit staff. Claims that represent special problems are referred to a second audit level, and from that point, are referred to a Medical Review Committee. This committee is composed of registered nurses, senior department personnel, and corporate associate medical directors. The function of the various audit levels is to determine whether or not the patient is an eligible beneficiary and whether the diagnosis and treatment received are proper benefits of the CHAMPUS Program. At one of these audit levels, a claim is released for appropriate payment or rejected. Providers may request a review of decisions through peer reviews at the state level or they may seek a review by OCHAMPUS.

Funds to cover payments to providers or beneficiaries are forwarded by wire by OCHAMPUS to Mutual's depository bank to cover CHAMPUS payments issued. A billing is sent to OCHAMPUS on a weekly basis covering the week's activities. The Mutual system maintains, on-line, eighteen months of patient records. In total, they maintain five years of patient records. Co-insurance and deductible calculations are taken by the computer and are maintained in the patient records. A three year patient deductible record is maintained in an active status in order to prevent duplicate payments.

Reports generated by Mutual's system include a monthly claims activity report, a weekly billing report, and any special reports requested by OCHAMPUS. Internally, reports on auditor productivity, claims distribution listings showing action taken on all items cleared through the computer, and bank reconciliations are generated on an automatic basis by the computer.

C. BLUE SHIELD OF CALIFORNIA

Except for the several geographic areas covered by Mutual of Omaha, most geographic area state medical associations, state Blue Shield organizations, or other similar service agencies or insurance companies process non-hospital type claims. Blue Shield of California is typical of these state organizations [Ref. 63].

Blue Shield receives about 20,000 CHAMPUS claims per week. About 60 percent of these claims are from providers, the

remainder from beneficiaries. Approximately 30 percent of the claims contain some type of error. About 95 percent of these errors can be corrected via telephone calls to the provider. Blue Shield experiences a 20 percent claims rejection rate. Claims cannot be processed and thus must be rejected for one of three main reasons:

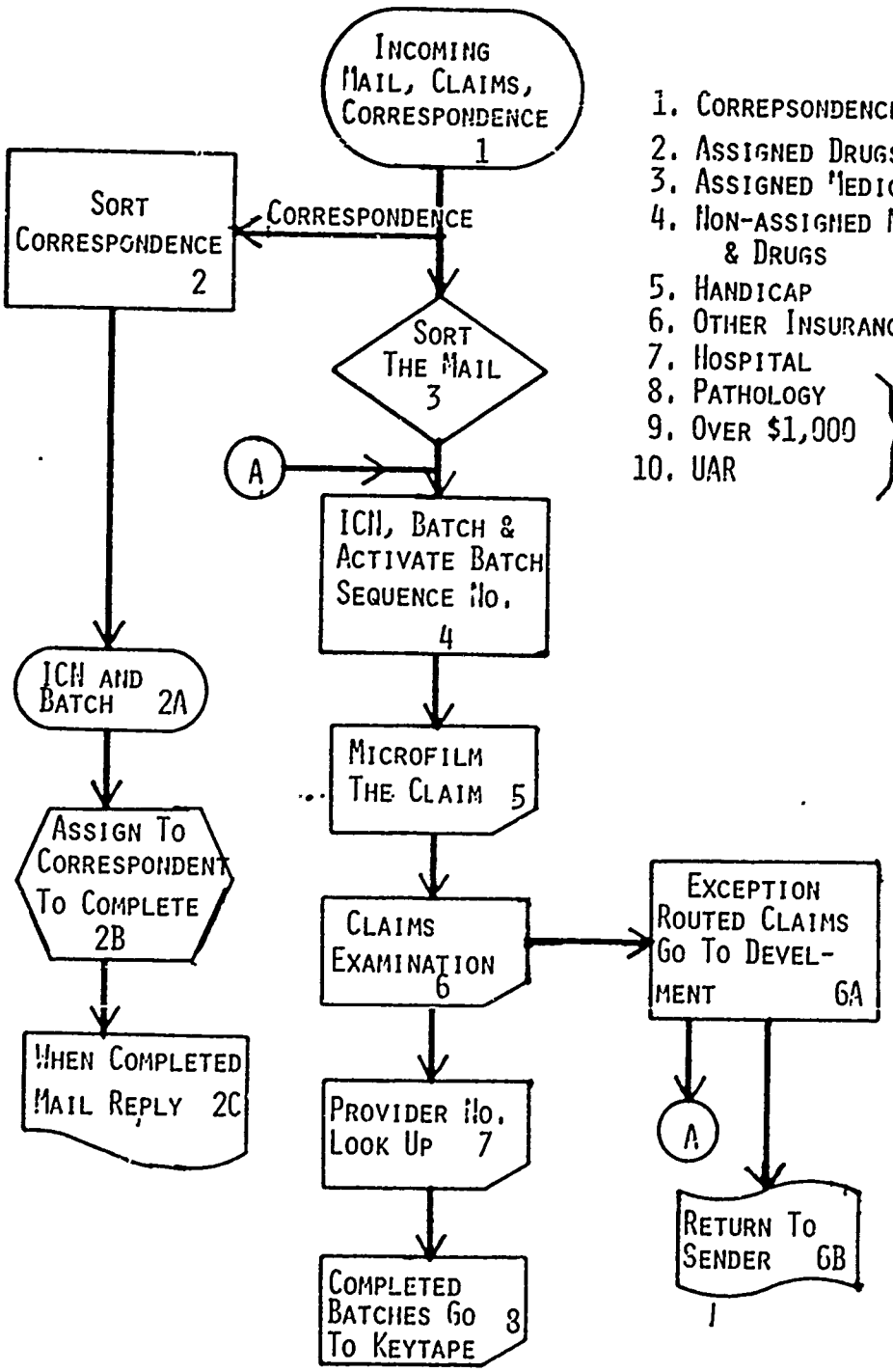
1. The deductible requirements have not been met.
2. The beneficiary is ineligible for treatment.
3. The care received is not a benefit under the CHAMPUS Program.

The Blue Shield claims rejection rate is higher than Blue Cross and Mutual for several reasons. First, Blue Shield handles all types of claims except hospital claims. The outpatient benefits are numerous and, in many cases, not specifically defined. It is felt that many providers, i.e., physicians accept a patient and treat a condition that they consider a benefit. During claim review the condition or treatment is determined not to be a benefit. Another reason for the high rejection rate is thought to be the lack of trained clerical personnel in most physician's offices. Normally, a physician will have one or two nurses in his office. These persons are not fully aware of the CHAMPUS benefits. Still another reason is thought to be that of "we're not certain so we'll submit a claim" reasoning by the dependent.

Exhibit 9, a simplified flow diagram, indicates the processing procedures used by Blue Shield of California. As

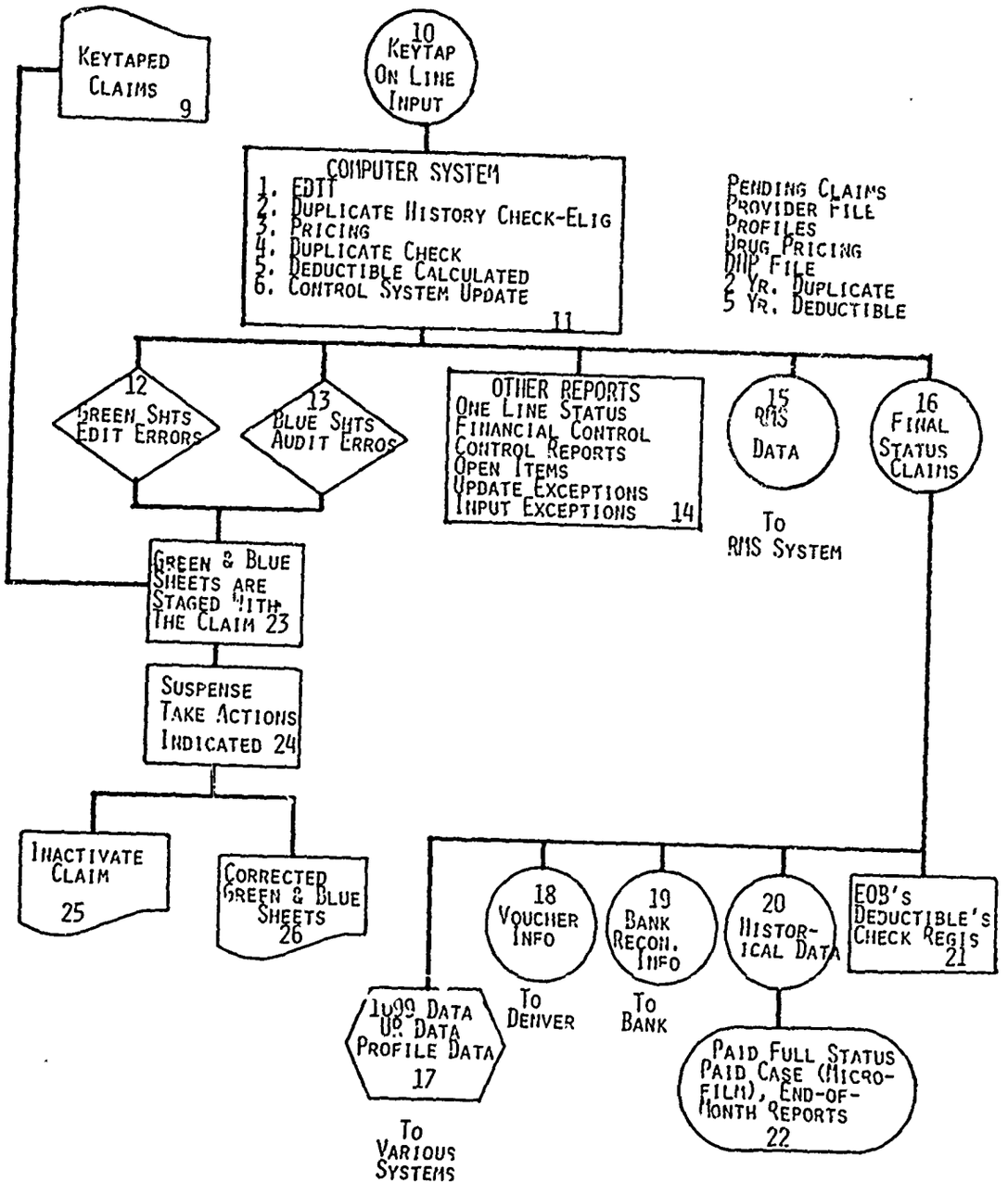
EXHIBIT 9-A

CHAMPUS SYSTEM



1. CORREPSONDENCE	6%
2. ASSIGNED DRUGS	2%
3. ASSIGNED MEDICAL	55%
4. NON-ASSIGNED MEDICAL & DRUGS	28%
5. HANDICAP	1%
6. OTHER INSURANCE	2%
7. HOSPITAL	5%
8. PATHOLOGY	
9. OVER $1,000	1%
10. UAR	

EXHIBIT 9-B


KEYTAPED CLAIMS 9
10 KEYTAP ON LINE INPUT
COMPUTER SYSTEM
1. EDIT
2. DUPLICATE HISTORY CHECK-ELIG
3. PRICING
4. DUPLICATE CHECK
5. DEDUCTIBLE CALCULATED
6. CONTROL SYSTEM UPDATE
11
PENDING CLAIMS
PROVIDER FILE
PROFILES
DRUG PRICING
DHP FILE
2 YR. DUPLICATE
5 YR. DEDUCTIBLE
12 GREEN SHTS EDIT ERRORS
13 BLUE SHTS AUDIT ERROS
OTHER REPORTS
ONE LINE STATUS
FINANCIAL CONTROL
CONTROL REPORTS
OPEN ITEMS
UPDATE EXCEPTIONS
INPUT EXCEPTIONS 14
15 RMS DATA
To RMS SYSTEM
16 FINAL STATUS CLAIMS
GREEN & BLUE SHEETS ARE STAGED WITH THE CLAIM 23
SUSPENSE TAKE ACTIONS INDICATED 24
INACTIVATE CLAIM 25
CORRECTED GREEN & BLUE SHEETS 26
1099 DATA OR DATA PROFILE DATA 17
To VARIOUS SYSTEMS
18 VOUCHER INFO
To DENVER
19 BANK RECON. INFO
To BANK
20 HISTORICAL DATA
PAID FULL STATUS PAID CASE (MICRO-FILM), END-OF-MONTH REPORTS 22
EOB'S DEDUCTIBLE'S CHECK REGIS 21

the claim is received, it is issued an Insurance Case Number (ICN) composed of one digit for the year, three digits for the Julian day of the year, a batch number, and a claim number within the batch. Prior to the assignment of an ICN, the claims are sorted into one of ten claims classifications used by Blue Shield (See Exhibit 9-A). They are also given a preliminary screening for completeness at this point. All claims are then batched according to classification and an ICN assigned. No more than fifty claims are assigned to the same batch number. After assignment of the ICN the claims are microfilmed and processing begins.

In the claims examination step claims are examined for correctness and completeness. Claims requiring development of missing or erroneous data are separated to a Claims Development Section. All possible errors are corrected by telephoning the provider for the missing information or to obtain the correct data. In case a telephone call cannot clear up the errors, the form is returned to the provider for completion and correction.

After all the data is obtained or corrected, the claims reenter the system. Claims that do not require additional work go to provider look-up where the provider's code is checked to ascertain whether he is a qualified, participating provider. From this point all the claims are collected by batches and sent to San Diego where they are keyed directly to computer tape by Blue Shield's computer services

contractor. The information on the tapes is then fed directly to the Blue Shield computer center in San Francisco via direct wire data link.

Blue Shield, as the Fiscal Administrator for the outpatient CHAMPUS Program in California, pays claims in accordance with the "usual," "customary," and "reasonable" charge concept. This is commonly referred to as a Provider Profile System, and is considered by Blue Shield as one of the most efficient and equitable mechanisms for administering payments to providers and beneficiaries.

On the other hand Blue Cross and Mutual, when processing inpatient claims, administer payments under one of three methods. The first method, a negotiated Per Diem Reimbursement, is not widely used. In this method of reimbursement a per diem figure for each day of covered care is arrived at by negotiation. The per diem rate need not be directly related to hospital charges or costs. Under this method the daily reimbursement decreases as days of hospitalization increase until a lower limit is reached. This method of reimbursement is not used by most hospitals because it is too difficult to justify to regulatory agencies.

The second method used is called Reimbursement Rate Based Upon Hospitals Retail Charges. Retail charges refer to regular room rates and normal billings for special service any patient would pay. These are now construed to mean a price at least equal to, and most probably above, the actual

cost per patient day of providing hospital accommodations. The retail charges are the maximum reimbursable limits. In many instances the "retail charge" is set as an average of all hospital in a given Blue Cross Plan. These rates are normally simple to derive but there is the constant possibility that some hospitals will overcharge. This method of reimbursement is also declining with most hospitals that use it located in the South.

The last, and most commonly used method, is termed Reimbursement Based Upon Hospital Costs. In this method the hospital is reimbursed for actual costs incurred in providing services. This method is a type of negotiated method in that Blue Cross or Mutual and the hospital must agree as to what allowable elements are to be used in calculating the costs. Normally, there is a minimum cost stipulation, called a floor, which is a certain percentage of each size or locational grouping of contracting hospitals. There are also ceilings, or maximum allowable costs, normally stated as a proportion of average costs among hospitals of similar nature and size. A "floor" rewards a hospital with costs which are less than the minimum while a "ceiling" penalizes a hospital with high costs (usually a specialty hospital). This method is amenable to hospitals non-profit status and insures that a hospital will receive amounts adequate to cover expenses. There is, however, some question that this method might encourage inefficiency.

Under the Provider Profile System, a provider's charge is considered an allowable charge if it is his "individual" charge for the service and if it is within the "area range" of charges made by providers in the same community for the same service, or if it is judged to be "reasonable" by local peer review, considering all of the medical facts and circumstances.

The criteria considered in determining allowable charges are individual charges (Usual) and area charge (Customary Range). Individual charge is the amount the provider usually and most frequently charges for a specific service. These charges are not necessarily uniform or static, but may vary among providers and with the passage of time. Area charge is the amount most frequently and most widely charged in a local community by providers for a specific service. These charges reflect factual data on an overall charge pattern existing within a specific and limited geographical area. They tend to cluster about a certain figure which might be statistically identified as the "mean" or the "median." The degree of specialization, population density, as well as other items concerned with the economics of a provider's practice, which may vary from one locality to another, are all taken into account in determining the area charge.

Every charge which a provider makes for services rendered to beneficiaries of Blue Shield-administered programs, and the Company's private business -- as indicated by submitted

claims -- are recorded to his account and stored on the company's computer tapes by provider name and license number, procedure or service rendered, billed charge, and his practicing address. A continuous record is kept of all charges made to the Fiscal Administrator from each provider for services he performs. These charges, over a given period of time, usually one year, are used as the data base in calculating the provider's profile.

The provider's individual charge for each of the services which make up his "profile" are updated annually in order to reflect changes which may have taken place in his pattern of charges. A general profile update is accomplished in July of each year and is based on all billed charges for the preceding calendar year. Thus, the update in July 1974 will be based on all billed charges for the period of January to December 1973.

To calculate the allowed charge, the "individual" charges for a specific service are arrayed from the lowest billed charge to the highest. For example, a provider submitted claims for 41 routine office visits; for ten of these visits he charged $10, for 15 visits he charged $12, and for the remaining 16 visits he charged $15. The median would be that point at which one-half of the 41 visits were charged. In this case, he charged $10 and $12 a total of 25 times and $15 on 16 occasions. Therefore, his individual charge is calculated to be $12. The allowable amount is then determined by

the lesser of the billed amounts, the individual profile, or the area charge. In this case, $12 would be the allowed amount.

Since Blue Shield does not pay claims on the basis of a fee schedule, but under the UCR concept, when the computer prints out a check for payment of an amount below that which was billed by a provider, it signifies that the billed charge was above the provider's individual charge or above the area range. It does not necessarily indicate that the charge was not reasonable as it may be justified concerning the special circumstances of that particular case.

Any provider who believes that his charges have been unfairly reduced, or that circumstances justify an increased fee in certain cases, has the right to request review by an Advisor of his specialty, or he can avail himself of the advice and assistance of his local peer review committee that each county and district medical society has appointed for that purpose. In recent Blue Shield history few providers have requested more than one review of disputed payments.

In no case, however, can a provider bill the patient for the difference between the amount he claimed and the amount he received. One of the provisions of agreeing to accept CHAMPUS patients is that of the full payment concept. Under this concept, the amount determined by the fiscal administrator to be the reasonable charge for the service provided is considered as payment in full. A physician agrees to this

concept when he signs and submits a claim. The only exceptin to this concept is for those charges that relate to a case which is not a proper benefit of CHAMPUS.

Under the terms of the existing contract that Blue Shield has with the Federal Government, one of the contractual obligations is that CHAMPUS payments conform to the concept of usual, customary, and reasonable, and that payments made to, or on behalf of, CHAMPUS beneficiaries, not be higher than payments made to, or on behalf of, the company's policyholders and subscribers, when services are comparable and furnished under comparable circumstances. The UCR is, as a matter of policy, used in determining payable amounts by Blue Shield in the operation of its private business as well as in the operation of its government business.

Several years ago, Blue Shield, in cooperation with its parent organization, the California Medical Association, conducted a Relative Value Study. This study formalized the procedures used by a physician and assigned each procedure a code number. Each procedure was also assigned a value in terms of units. The definition of a unit of value as used in the RVS is vague. For example, the 1969 RVS states that the unit value for a brief evaluation, history, examination and/or treatment for a new patient is 20.0. For an established patient a brief examination, evaluation and/or treatment of the same or new illness has a unit value of 12.0. The only difference in the two is the new patient receives a history. Does the taking of a medical history have a value of 8.0, the

difference in the above values? One cannot say for certain because an initial limited history and physical examination for a new patient has a unit value of 30.0.

Thus one must conclude that the concept of unit value centers around the time involved, the types of services provided, the types of and the amount of supplies and materials used, the use of paramedical personnel (nurses) and the amount of knowledge or expertise that must be utilized in providing the service.

A unit of value was further assigned a dollar amount. It is from this study that the physician's reasonable fee is computed. For example, an office visit may be assigned the RVS code number 9004. Assume that the usual value for this procedure is four units based on the time involved, the complexity of care provided, and all other factors. Further assume a unit of value is worth $6. Thus, a "reasonable" fee for an office visit is computed to be $24. Using this system permits Blue Shield to compute "reasonable" fees in those special cases where the usual or customary fee is not applicable.

It is important to note that an individual physician's "usual" fee rate may be influenced by his offering of "professional discounts." These discounts, normally offered to other physicians and other medical personnel, tend to lower his "usual" fee since they are part of the overall collection of billed charges that Blue Shield maintains in the Provider

Profile System. It is also interesting to note that, on occasion, a provider can influence his "usual" fee by moving the location of where he provides the service. Thus, by moving from an area close to a hospital to an area further removed from the hospital he may be able to raise his usual fee. The effect of such a move would not, however, be reflected in the payments he receives until a year later because of the time lag in adjusting the pricing mechanism in Blue Shield's system.

An interesting feature of the Blue Shield System is that the computer automatically generates audit sheets. A Green Sheet Audit, titled CHAMPUS CORRECTIONS, printed appropriately on green paper, is generated when errors are encounted in the patient history data. That is, errors are found in Items one through thirteen of the claim form. These Green Sheet Audits, a sample of which is shown in Exhibit 10, are collated with the claim containing the errors. When the error has been corrected, the audit sheet's corrections are entered into the computer through on-line cathode ray tube and control units.

Blue Sheet Audits, titled CHAMPUS SUSPENSION LISTING, printed on blue paper, are automatically generated when provider identification and/or pricing errors are encountered. These errors are corrected and fed into the computer in the same way as are the Green Sheet Audits. Uncorrectable data on either of the audit sheets causes the claim to be returned

EXHIBIT 10

CHAMPUS CORRECTIONS

02/04/75 PAGE 2 OF 2 1

01175

ACTION	ICN	SPONSOR NUMBER	CLERK	
	502771305 5	539244845		FIRST RECORD
	502771305 5	539244845		SECOND RECORD SEE CORRECTIONS

ACT	SERVICE NUMBER	SOCIAL SECURITY NUMBER	SPONSOR LAST NAME			STAT	BOS	GRADE	CLERK
A0 00	019416694	539 24 4865	HARRIS	E	C	2	1	E	567C

ACT		TOTAL NAME	PATIENT PAID	OTHER INSURANCE	DEDUCTIBLE	CENT	STAT	ROC	IHAC NO.
A6 00	V	LINES 08	19 50	00	00	1	2		381

ACT	PATIENT FIRST NAME	MI	REL	DATE OF BIRTH	BEGINNING DATE	ENDING DATE	HANDICAP	TYPE	FACIL
A1 00	YAEKO		1	08 21 27	05 22 72	05 22 78			

ACT	PATIENT STREET ADDRESS	CITY	STATE	ZIP CODE
A2 00	787 ELLEN LN	EL CAJON	CA	92021

ACTION	DATE TREATED	PROCEDURE CODE	REFILL	AMT BILLED	PROF FEE TOS	QUAN	PAID BY OR DUE FROM PATIENT	ACQUISITION COST	PROVIDER NUMBER	PROV NAME	PROV CODE	N-C MSG	DRUG CODE
*A907	*11 14 75	99070		2 50	C	01.0			*	*	51		9988
*A908	*11 14 75	99070		2 50	C	01.0			*	*	51		9988

027 713 DETAIL TOTAL ▶ 50 00 CLAIM CONTAINS 18 EDIT ERROR(S) INDICATED BY ASTERISKS.

REMARKS ▶

to whomever originally submitted it to Blue Shield. Exhibit 11 is a sample of this form. When all of the indicated corrective actions have been taken, the carbon copies of these audit sheets are filed with the batched claims. The originals of the audit sheets are disposed of in a recycling process.

One of the main reports generated by the Blue Shield system is a "one-line status report." This report is generated at the completion of each batch run and provides Blue Shield with the status of every claim in process or completed during the run. A sample page of the report is shown in Exhibit 12. In reading the report the notation "pended claim" in the check number column indicates a claim in which some data is missing or is incorrect and, as a result, a Green Sheet Audit or a Blue Sheet Audit was printed. Such claims are held in an active status in the computer for 30 days. The notation "delete" in the Check Number column indicates a claim which has been rejected by the system.

Blue Shield keeps a microfilm record of all claims for two years and retains microfilm records of processing actions for five years. Samples of these two microfilm records titled "CHAMPUS PAID FULL LISTING - DECEMBER 1974" and "CHAMPUS ALPHABETIC CROSS REFERENCE" are shown in Exhibits 13 and 14 respectively. These files are necessary to keep track of deductibles and co-insurance to prevent duplicate claims and to provide a complete family history as required by CHAMPUS regulations.

EXHIBIT 11

3136 CALIFORNIA BLUE SHIELD **CHAMPUS SUSPENSE LISTING** 01-14-75 PAGE 04 OF 4 1

ACT	CN	SPONSOR NUMBER	CLERK
	500980002 9	558360861	

ACT	LINE	SPONSOR LAST NAME	FI	MI	SERVICE NUMBER	SOCIAL SECURITY NO	CLERK	HANDICAP	TYP	ACT
	00	DAVIS	O	J		558 36 0861	C21S			

ACT	LINE	ASN	PATIENT LAST NAME	MI	DEDUCTIBLE	CAG	BPK	TOTAL BILLED	PATIENT PAID	OTHER INS	
	00	V	NORMA	J	0 00	508		LINES 17	0 00	0 00	P:00 C:44

ACT	LINE	ACT	DATE FILED / DATE OF SERVICE	PRESCRIPTION NO / PROCEDURE NO	AMOUNT BILLED	N/R TOS	MULT SERV	PROV CODE	PROVIDER NUMBER	PROV NAME	N/C MSG	DRUG CODE	PRICE ADJ	ACT
	16	A9	11 25 74	99070	28 00	C	1 0	51	00C123680	RO		9988	0 00	

	REJECT REASON	DUPLICATE ICN	DATE PAID	DUPLICATE ICN	DATE PAID	ACT
21K	M/P - R/C - - - - MR					

	LOC	LEVEL 1	LEVEL 2	LEVEL 3	PRICING MESSAGE
0 71	01	0 00C	0 00	0 00	BY REPORT PROCEDURE ON RVS FILE

ACT	LINE	ACT	DATE FILED / DATE OF SERVICE	PRESCRIPTION NO / PROCEDURE NO	AMOUNT BILLED	N/R TOS	MULT SERV	PROV CODE	PROVIDER NUMBER	PROV NAME	N/C MSG	DRUG CODE	PRICE ADJ	ACT
	17	A6	10 10 74	90050	11 00	I	1 0	51	00C123680	RO	40	9005	10 50	

	REJECT REASON	DUPLICATE ICN	DATE PAID	DUPLICATE ICN	DATE PAID	ACT
21K	- - - - -					

	LOC	LEVEL 1	LEVEL 2	LEVEL 3	PRICING MESSAGE
0 71	01	11 00	10 50	11 40	REAS AT LEV1/CUT AT LEV2 /REAS AT LEV3/ PAY LEVEL 2

009 800

EXHIBIT 12

HHOP310F-OL CYCLE DATE 01/07/75 CHAMPUS ONE LINE STATUS REPORT FRAME 1533

SPONSOR'S LAST NAME	PATIENT'S FIRST NAME	M I	SEX REL	SPONSOR NUMBER	S T	CL TY	CLAIM NUMBER	PRE LOC	NUM DYS	VEND NAME	CKDT MMDD	CHECK NUMBER	CHECK AMOUNT	BILLED AMOUNT	PAT PAID AMOUNT	DEDUCT-IBLE	CO-INS
ZOECKLEIN	WALTER		4	301050902	2	DV	431850002A	426	121	PEARS	1219	2234120	33.83	45.12	11.27		11.25
ZOECKLEIN	WALTER		4	301050902	2	MV	452571023A	016	135	LOMA	1205	2212370	8.44	12.50			2.83
ZOELNER	ERIC		3	498123960	2	MV	434372447A	4061		SCHLU	0107	0	15.00	70.00		50.00	5.00
ZOELNER	ERIC		3	498123960	2	MV	434372447B	4061		SCHLU	0107	0	97.50	180.00		50.00	32.50
ZOGORSKI	DOROTHY		1	580382138	2	MV	432372803A	336	235	SCHNE	1205	3390725		12.00		12.00	
ZOGORSKI	DOROTHY		1	580382138	2	MV	432372803B	336	135	SCHNE	1205	2214526	36.75	99.00		50.00	12.25
ZOHRLAUT	SHIRLEY	R	1	555526036	2	MP	432972345	415	121	MAGER	1213	DELETE		59.75			
ZOHRLAUT	SHIRLEY	R	1	555526036	2	MP	435830015A	3361		PARKV	1219	2238178	18.69	22.25			5.56
ZOHRLAUT	SHIRLEY	R	1	555526036	2	MP	434540137A	016	121	SPECI	0107	0	19.88	28.50			6.62
ZOLBY	MARGARET	C	1	044275001	2	MV	434672340A	016	212	ALLEN	1230	2248835	24.00	101.50	77.50	28.50	17.25
												2248836	27.75		REFUND TO PATIENT		
ZOLBY	MARGARET	C	1	044275001	2	MV	435071611A	3161		WERNE	0107	0	30.00	60.00			10.00
ZOLBY	EUGENE		3	044275001	2	MP	434540137A	026	121	SABRA	1219	3530678		16.50		16.50	
ZOLBY	MARGARET	C	1	044275001	2	MV	438171531A	0161		AMERI	0107	0	31.13	48.00			10.37
ZOLLER	TAMMY	A	2	575324903	1	MV	435771243B	0162	7	SANTA	1231	2253290	112.50	175.00			37.50
ZOLLER	TAMMY	A	2	575324903	2	MV	435771243A	0161	7	SANTA	1231	3850281		15.00		15.00	
ZOLLINGER	JANICE	L	1	560228976	1	MV	435479622A	016	128	SMITH	1212	2224638	7.50	60.00		50.00	2.50
ZOLLO	ERNEST	G	4	050189237	2	MV	432930223A	346	112	BUNKS	1230	2245813	412.50	600.00			137.50
ZOLLO	ACQUELINE	M	1	050189237	2	MV	434779706	314	518	RYAN	1220	PENDED CLAIM					
ZOMPETTI	GLORIA	R	1	561667682	1	MV	432370004B	346	228	ORANG	1212	2224058	865.00	900.00			
ZOMPETTI	GLORIA	R	1	561667682	2	MV	432370004A	346	228	ORANG	1212	3460351		15.00		10.00	
ZOMPETTI	GLORIA	R	1	561667682	1	MV	434772843	013	118		1220	PENDED CLAIM		170.00			
ZOOK	JAMES		3	526013084	1	MV	432531115A	316	128	LOMPO	1212	2228900	12.60	16.80			4.20
ZORBLA	MARY	J	1	462301865	1	MV	434771839A	336	112	GELLI	1230	2249064	58.50	100.00			19.50
ZORBLA	MARY	J	1	462301865	1	MV	434771648A	4061		ROSEM	0107	0	73.65	107.00			24.50
ZORBLA	MARY	J	1	462301865	1	MV	435480035A	3161		CLEM	0107	0	75.00	130.00			25.00
ZORBLA	MARY	J	1	462301865	2	MV	436470042	0140		MARTI	0107	PENDED CLAIM		585.00			
ZORBLA	MARY	J	1	462301865	1	MV	430970848A	406	118	NAMIH	1223	2242854	506.10	825.00			188.70
ZORBLA	MARY	J	1	462301865	1	MV	433772624A	016	128	HOIEN	1212	2225779	78.98	115.00			26.32
ZSEDENY	DORA		1	222134320	2	MV	430878504A	456	132	HART	1209	2218627	13.72	179.10	64.10	41.96	3.42
ZUBAK	IVAN	S	4	298121423	2	MV	432980187	314	232	JOHNS	1206	PENDED CLAIM		250.00			
ZUBER	DORI		2	516308044	1	MV	433079623A	0162	7	FRENC	1231	3850093		22.80		22.80	
ZUBIATE	MICHELE		2	550817293	2	MV	435470932A	016	135	LEGOM	1205	2213762	77.78	120.00			25.92
ZUBIATE	MICHELLEY		2	550817293	1	MV	435770210	3331		FRENC	0107	PENDED CLAIM		16.00			

EXHIBIT 13

485
FILM DATE JANUARY 01, 1975 CHAMPUS PAID FULL LISTING - DECEMBER 1974 FRAME 7211

SPONSOR-# ALTERNATE-# SPONSOR-NAME BOS GRD STAT DEDUCT-YEAR-SET DEDUCT-YEAR-SET DEDUCT-YEAR-SET DEDUCT-YEAR-SET
:85421610 003198357 MAASSEN LR 4 0 ACT 60.00 74-75 15.00 73-74 50.00 72-73

PATIENT-NAME BIRTHDTE REL HDCAP ELIGDATE EXPRDATE DEDUC-YEAR-SET DEDUC-YEAR-SET DEDUC-YEAR-SET DEDUCT-YEAR-SET
CAROLYN M 01-28-41 1 01-30-72 01-30-78 60.00 74-75 15.00 73-74 50.00 72-73

CLAIM-NUMBER END-CARE CLM-TYP BASIS DIAG CERTS AMT-BILL OTHERINS PAT-PAID PA-MTHD AMT-DED SET CO-INSUR PROV-NAM
4162-801-024 04-11-74 M-V 2 626 27.50 B 27.50 ADAMS
CHECK-DATE CHECK-1-# CHECK-1-AMT CHECK-1-EOB CHECK-2-# CHECK-2-AMT CHECK-2-EOB
06-21-74 1720443

DATE-SER MULT TOS 64RVS 69RVS PC-ENT OA MA PROV-NUM CODE LEVEL-1 LEVEL-2 LEVEL-3 AMT-BILL AMT-DED AMT-PABL EOB
04-11-74 1.0 1 9019 9001500 69 A6 00C293850 51 20.00 35.00 36.50 27.50 20.00 40

CLAIM-NUMBER END-CARE CLM-TYP BASIS DIAG CERTS AMT-BILL OTHERINS PAT-PAID PA-MTHD AMT-DED SET CO-INSUR PROV-NAM
4162-801-028 05-14-74 M-V 2 626 815.00 B ADAMS
CHECK-DATE CHECK-1-# CHECK-1-AMT CHECK-1-EOB CHECK-2-# CHECK-2-AMT CHECK-2-EOB
05-21-74 1939484 615.00
DATE-SER MULT TOS 64RVS 69RVS PC-ENT OA MA PROV-NUM CODE LEVEL-1 LEVEL-2 LEVEL-3 AMT-BILL AMT-DED AMT-PABL EOB
05-14-74 1.0 2 4614 5815000 69 A6 00C293850 01 533.30C 560.00 580.40 690.00 533.30 40
05-14-74 -.50 2 4612 5812050 69 A6 00C293850 01 66.70C 75.00 72.60 100.00 66.70 40
05-14-74 1.0 2 4512 5741050 69 A6 00C293850 01 24.00C 15.00 26.20 25.00 15.00 40

CLAIM-NUMBER END-CARE CLM-TYP BASIS DIAG CERTS AMT-BILL OTHERINS PAT-PAID PA-MTHD AMT-DED SET CO-INSUR PROV-NAM
4178-711-244 05-14-74 M-V 2 625 163.00 B LAUDE
CHECK-DATE CHECK-1-# CHECK-1-AMT CHECK-1-EOB CHECK-2-# CHECK-2-AMT CHECK-2-EOB
07-15-74 1971100 128.00

DATE-SER MULT TOS 64RVS 69RVS PC-ENT OA MA PROV-NUM CODE LEVEL-1 LEVEL-2 LEVEL-3 AMT-BILL AMT-DED AMT-PABL EOB
05-14-74 1.0 3 4614 5815080 69 A6 00C157390 03 130.00 128.00 115.40 163.00 128.00 40

CLAIM-NUMBER END-CARE CLM-TYP BASIS DIAG CERTS AMT-BILL OTHERINS PAT-PAID PA-MTHD AMT-DED SET CO-INSUR PROV-NAM
4199-798-274 05-14-74 M-V 2 629 168.00 B LIPPM
CHECK-DATE CHECK-1-# CHECK-1-AMT CHECK-1-EOB CHECK-2-# CHECK-2-AMT CHECK-2-EOB
07-25-74 1992882 160.00

DATE-SER MULT TOS 64RVS 69RVS PC-ENT OA MA PROV-NUM CODE LEVEL-1 LEVEL-2 LEVEL-3 AMT-BILL AMT-DED AMT-PABL EOB
05-14-74 11.0 7 4614 5815040 69 A6 00G144830 02 160.00C 164.80 168.00 160.00 40

EXHIBIT 14

FILM DATE: 01/25/75 — CHAMPUS ALPHABETIC CROSS REFERENCE — FRAME 19882

SPONSOR NAME / DEPENDENT NAME	BOS	SPONSOR SOC SEC NO / DEPENDENT BIRTHDATE	AGE IMD	SEX REL	SPONSOR SERVICE NO	SPON STAT	INEL	SPONSOR ADDRESS / DEPENDENT DEDUCTIBLE 70-71	71-72	72-73	73-74	74-75	DEPENDENT ID CARD NUM	ELIGIBILITY BEGIN	ELIGIBILITY END	FAMILY DEDUCTIBLE 70-71	71-72	72-73	73-74	74-75	OTHER INS	TELEPHONE NUMBER
MAASJR	E	R 2			000053905																
OPAL •		V 3/24/36		1																	
MAASS	R	E 1 0050554839			000337454	RET		915 1/2 ELM AVE													
								LONG BEACH					CA 90813								
ROBERT		E 7/12/11	4													50.00	50.00	98.40	14.00		
ROBERT		3/11/56	3					50.00	50.00	50.00	14.00		1043579	8/20/71	12/31/99	1					
										48.40			GL865003	5/09/73	03/10/77	1					
MASS	M	O 8 023888185				RET		6973 ST MARK CT													
								SANTA ROSA					CA 94501								
TRICIA		8/28/73	2																	100.00	17.35
SHAWN		5/ 3/71	2					50.00	17.35				23888185C	9/01/73	08/28/91	1					
								50.00					23888185D	9/01/73	05/03/89	1					
MAASS	F	K 4 3657648924				DEC		23566 MACKERAL AVE													
KAREN		B 9/25/61	2													50.00	50.00	50.00	50.00	28.00	
HELEN		4/12/41	1		50.00	50.00	50.00	50.00	28.00				N13445354	6/24/73	08/01/79	1					
STEVEN		M 4/12/63	3										N13445353	6/24/71	08/01/77	1					
													N13435387	6/24/73	08/01/79	1					
MAASSEN	R	R 4 385337081			000603843	ACT															
MARY		K 1/19/45		1																	
MAASSEN	L.R	4 485421610				ACT		373 C BERGIN DR													
								MONTEREY					CA 93940								
CAROLYN		M 1/28/41	1					27.50					N10222256	1/30/72	01/30/78						27.50

Blue Shield receives payment directly from OCHAMPUS in the same way as Mutual does. Once a week an estimate of the dollar amounts to be paid is wired to OCHAMPUS. OCHAMPUS responds by depositing funds in Blue Shield's depository bank. The estimates are followed up by a more detailed invoice and OCHAMPUS makes the appropriate adjustments in subsequent payments. Copies of computer tapes of claims processed are also sent to OCHAMPUS.

Blue Shield reports that it is currently able to process and make payment on over 80 percent of the CHAMPUS claims in five to seven days. The system will hold a "pended" claim for thirty days and will then generate a special follow-up report. Further action is taken if no response is received by the end of 45 days.

V. CLAIMS PROCESSING - OCHAMPUS

Upon completion of the claims processing by one of the 47 fiscal administrators/hospital contractors, a check is sent to either the provider or to the beneficiary as applicable. The contractor then submits a bill to OCHAMPUS for reimbursement. This chapter will examine the process by which OCHAMPUS adjudicates the contractor's claim [Ref. 64].

A. CONTRACTOR ADVANCES

As noted earlier, the contractor begins the reimbursement procedure by telephoning OCHAMPUS for an advance of funds to offset the checks being mailed out. This procedure, referred to as a wire or telegram in the preceding chapter, is received in the Finance and Accounting Division of the Contract Management Directorate of OCHAMPUS. Whomever answers the telephone records each call on a preprinted "Routine and Transmittal Slip," Optional Form 41 shown in Exhibit 15. The name of the person calling, the state contractor he represents, the amount requested, the invoice number, and the period covered are carefully noted and are repeated back to the caller to verify accuracy. The person taking the call then signs and dates the slip. Additionally, the exact time of the call is noted on the form.

During the call the person in the F&A Division checks a blackboard euphemistically termed the "Advances Status Board." If a state contractor has two or more outstanding

EXHIBIT 15

ROUTING AND TRANSMITTAL SLIP		ACTION
1 TO STATE:	INITIALS	CIRCULATE
	DATE	COORDINATION
2 PERSON CALLING:	INITIALS	FILE
	DATE	INFORMATION
3 PARTIAL PAYMENT NO:	INITIALS	NOTE AND RETURN
	DATE	PER CONVERSATION
4 VOUCHER NUMBER:	INITIALS	SEE ME
	DATE	SIGNATURE

REMARKS

AMOUNT $ _____

INVOICE NUMBER:

PERIOD COVERED:

Do NOT use this form as a RECORD of approvals, concurrences, disapprovals, clearances, and similar actions

FROM	DATE
	PHONE

OPTIONAL FORM 41
AUGUST 1967
GSA FPMR (41CFR) 100-11.206

5041-101

1

advances, that is, advance payments that have not been substantiated by an invoice, they are advised that no further advances will be processed until the oldest of the advances have been invoiced to OCHAMPUS. If their state is not on the board their advance funds request is processed. The processing procedure begins with the assignment of a Voucher Number. This number is composed of the fiscal year plus a four digit consecutive code. For example, 75-1818 represents the 1,818th voucher for Fiscal Year 1975. Next a Standard Form 1034, Public Voucher for Purchases and Services Other Than Personal, is prepared. This form is shown in Exhibit 16. These forms are collected and taken to the Fitzsimmons Army Medical Center Disbursing Office daily at 2:00 P.M. This office processes the vouchers, sends the necessary data to the OCHAMPUS Computer Operations Division for check preparation, and returns to collect the prepared checks the following day.

When the OCHAMPUS F&A personnel appear at the Disbursing Office with the next batch of vouchers, they pick up the completed vouchers and checks from the preceding day's batch. These checks are taken immediately to the branch bank located on the FAMC grounds where they are deposited in a special account. Special deposit slips listing the voucher numbers and check amounts are prepared and signed by the bank manager. At 3:00 P.M. that same day the checks are taken by special bank messenger to the main bank office in downtown Denver. Early the next morning the bank sends the funds

EXHIBIT 16

Standard Form No. 1034 7 GAO 5000 1034 11106	**PUBLIC VOUCHER FOR PURCHASES AND SERVICES OTHER THAN PERSONAL**	VOUCHER NO.
U.S. DEPARTMENT, BUREAU, OR ESTABLISHMENT AND LOCATION **DEPARTMENT OF THE NAVY**	DATE VOUCHER PREPARED CONTRACT NUMBER AND DATE REQUISITION NUMBER AND DATE	SCHEDULE NO. **PAID BY**
PAYEE'S NAME AND ADDRESS		DATE INVOICE RECEIVED DISCOUNT TERMS PAYEE'S ACCOUNT NUMBER
SHIPPED FROM / TO / WEIGHT		GOVERNMENT B/L NUMBER

NUMBER AND DATE OF ORDER	DATE OF DELIVERY OR SERVICE	ARTICLES OR SERVICES (*Enter description, item number of contract or Federal supply schedule, and other information deemed necessary*)	QUANTITY	UNIT PRICE COST	UNIT PRICE PER	AMOUNT (1)
(Use continuation sheet(s) if necessary)		**(Payee must NOT use the space below)**			**TOTAL**	

PAYMENT:	APPROVED FOR	EXCHANGE RATE	DIFFERENCES	
☐ COMPLETE	=$	=$1.00		
☐ PARTIAL	BY[2]			
☐ FINAL				
☐ PROGRESS	TITLE		Amount verified, correct for	
☐ ADVANCE			(*Signature or initials*)	

Pursuant to authority vested in me, I certify that this voucher is correct and proper for payment.

(*Date*) (*Authorized Certifying Officer*[2]) (*Title*)

ACCOUNTING CLASSIFICATION (Revised 7 65) (Appropriation Symbol must be shown, other classification optional)

Appropriation Symbol and Subhead	Object Class	Bureau Control and Suballot. No.	Auth. Acctg. Activity	Type	Property Acctg. Acty.	Cost Code	Amount

I.R. No's

PAID BY	CHECK NUMBER	ON TREASURER OF THE UNITED STATES	CHECK NUMBER	ON (*Name of bank*)
	CASH $	DATE	PAYEE[3]	

[1]When stated in foreign currency, insert name of currency
[2]If the ability to certify and authority to approve are combined in one person, one signature only is necessary; otherwise the approving officer will sign in the space provided, over his official title.
[3]When a voucher is executed in the name of a company or corporation, the name of the person writing the company or corporate name, as well as the capacity in which he signs, must appear. For example "John Doe Company, per John Smith, Secretary", or Treasurer, as the case may be

PER

TITLE

☆ U. S. GOVERNMENT PRINTING OFFICE 1970 - 389 776

out over the Federal Reserve System's Bank Wire System, a direct telegraphic wire system. The funds go directly to the contractor's depository bank for deposit and advice. The latter term means that someone in the receiving bank will notify the contractor of the receipt of funds. (It should be noted that each bank wire costs the OCHAMPUS command $4.50. Over $600 per month is spent on these bank wires.)

When the completed vouchers are returned to the F&A Division, the appropriate entries are made in the accounting ledgers to record the commitment of the funds. The average processing time for advances is thus about 2.5 days from receipt of the telephone request for funds to actual receipt of the funds by the contractor.

B. CONTRACTOR INVOICES

As a follow-up procedure, each contractor is required to submit an invoice and a computer tape of all claims included in the invoice period. Included in the invoice package is a Control Listing which provides, in summary form, the total number of claims by claim category, i.e., Physician, Hospital, Drug, Handicapped, etc., and the total professional charges for each category of claim. Exhibit 17 is an example of such a control listing. Copies of actual invoices were not available from OCHAMPUS or the contractors previously discussed.

EXHIBIT 17

MC508 CONTROL TOTALS FOR IOWA STATE NO. 14 01/04/75

VCU-NR 751818 INV-NR 000215 PHY/HOSP/DEN = 15,558.02 HDCP = .00 DRUGS = 2,029.78

TOTAL RECORD COUNT	TOTAL LINE ITEMS	TOTAL PAID BY PATIENT	TOTAL AMOUNT DUE FROM GOVERNMENT	TOTAL AMOUNT REIMBURSEMENT PATIENT OR SPONSOR	TOTAL	DIFF.
440	438	5,551.46	13,279.82	4,307.98	17,587.80	.00

Upon receipt of an invoice package the OCHAMPUS Mail Room initiates a CHAMPUS Form 174, OCHAMPUS Voucher Transmittal, by entering an internally controlled batch number and the date received. The same information is placed on a label which is attached to the reel of computer tape. The original of the Form 174, shown in Exhibit 18, is sent to the Finance and Accounting Division with the contractor's Control Listing and the Invoice. The copy of the form, which is printed on yellow paper, is sent with the computer tape to the OCHAMPUS Computer Operations Division.

The Finance and Accounting Division, upon receipt of their portion of the invoice package, completes the data on the Voucher Transmittal using the data on the invoice and the control listing. They also add the Voucher Number. This Voucher Number will be the same one that was used in the processing of the contractor's request for advance funds, except that it will have a Roman numeral suffix. For example, the voucher number cited above was 75-1818. The Voucher Number used for the follow-up incoice would be 75-1818(II) signifying the second use of that number. During the process of completing the Voucher Transmittal form the beginning and ending dates of the invoice are carefully compared to the dates of the period covered on the Routing and Transmittal Slip and the SF 1034 prepared during the processing of the request for advance funds.

EXHIBIT 18

OCHAMPUS VOUCHER TRANSMITTAL

BATCH NUMBER [| | |]

DATE RECEIVED [| | | | | |] (Y Y M M D D)

CARD ID [*] (1)

CONTRACT NUMBER [| | | | | |] (2 3 4 5 6 7)

FISCAL YEAR & VOUCHER NUMBER [| | | | | |] (8 9 10 11 12 13)

FM STATE CODE [| |] (14 15)

INVOICE DATES — BEGINNING [| | | | | |] (Y Y M M D D / 16 17 18 19 20 21) ENDING [| | | | | |] (Y Y M M D D / 22 23 24 25 26 27)

INVOICE NUMBER [| | | | | |] (28 29 30 31 32 33)

CLAIM RATE ADMIN FY [| | | |]

PHYSICIAN/DENTAL or HOSPITAL TOTAL $ [| | | | | | | | | CR] (34 35 36 37 38 39 40 41 42)

PHYSICIAN/DENTAL or HOSPITAL CLAIMS [| | | | | CR] (43 44 45 46 47)

PRESCRIPTION TOTAL $ [| | | | | | | CR] (48 49 50 51 52 53 54)

PRESCRIPTION CLAIMS [| | | | CR] (55 56 57 58)

HANDICAP TOTAL $ [| | | | | | | | CR] (59 60 61 62 63 64 65 66)

HANDICAP CLAIMS [| | | | CR] (67 68 69 70)

FM PROCESSING DATE [| | | | | |] (Y Y M M D D / 71 72 73 74 75 76)

DATE BALANCED [| | | | | |] (Y Y M M D D)

CHAMPUS FORM 174 PREVIOUS EDITIONS OF THIS FORM ARE OBSOLETE.

The established claim rate used to compute the contractor's administrative costs is also entered on the form. This rate, determined by past experience and by contract provisions, is normally a flat rate of a certain amount per claim. Occasionally, when a contractor has a new contract or has changed its processing procedures, a Provisional Claim Rate is used. This rate is based on the number of claims expected to be processed and the assets, people and equipment needed to do the processing. At the end of the year this rate will be audited by HEW auditors and, if indicated, appropriate adjustments will be made in the rate. Five states have provisions in their contracts that direct them to report actual direct claims processing costs for the period covered. These states are California, Washington, Connecticut, Wisconsin, and Idaho. Why these five states are treated differently was not explained by the OCHAMPUS officials. It was pointed out, however, that the direct costs, when translated into a claim rate, are quite comparable to the amounts paid to the other fiscal administrators.

When the Voucher Transmittal has been filled out, it is sent back to Data Processing. The invoice and the contractor's Control Listing are retained by the F&A Division for later use. In order to keep up with the workload the above steps for each invoice package must be completed by 3:00 P.M. each day. At this point it should be noted that the F&A Division has only eight persons and must process an average of ten

advance payment requests and 20 invoice packages per working day.

At the Computer Operations Division the completed original Voucher Transmittal information is keypunched onto a card which will be used as a "header" to the computer tape. During the night the header cards and the computer tapes are run through the computer where the computer tapes are balanced to the invoices, and at the same time, edited for errors. Occasionally during a computer run, a tape is rejected. Rejections are typically encountered because the contractor has modified his coding system and has not informed OCHAMPUS, or the contractor's claims processing computer operations cycle did not coincide with the financial cycle indicated on the invoice. When the latter occurs, record count on the tape will not match record count on the header card and, to save processing time, the tape is rejected by the OCHAMPUS computer.

The following morning the F&A Division receives a list of processed and rejected voucher invoices. The processed vouchers printout is shown in Exhibits 19 and 20. The Control Listing is compared with the "Summary By Fiscal Year and Branch" part of the Voucher Listing to ascertain correctness of totals. The "Summary by Branch" part of the processed Voucher Listing is used to calculate administrative costs and will be discussed in a later section. Accompanying each processed Voucher Listing is an "Edit Error List." Edit errors are of two types. A "Hard" edit error, shown in

EXHIBIT 19

VOUCHER PRINTOUT

MC14P L02D 24/04/75 PAGE 1

IOWA STATE NO. 14

VOUCHER NUMBER 75-1818 SUMMARY BY FISCAL YEAR & BRANCH

FIS. YR.	BR. SV.	CLAIMS	HOS. DAYS	AMT. DUE GOVT
2122020	06-4075 P8400-2572 FIC 841214.12000.000 SO5114			
72	ARMY	2		39.50
TOTAL FY 72		2		39.50
* *				
2132020	06-5075 P8400-2572 FIC 841214.12000.000 SO 5114			
73	ARMY	5		149.25
TOTAL FY 73		5		149.25
* *				
2142020	06-8030 P8400-2572 FIC 841214.12000.000 FO5114			
74	ARMY	36		296.20
	MARINE	1		175.00
	NAVY	12		669.96
	NAVY & MC	13		844.96
	AIR FORCE	20		823.97
	VET ADMIN	2		69.75
TOTAL FY 74		71		2,034.88
* *				
9750100.6300	63-1303 P6300-2572 FIC 630000.12000.000 SO5114			
75	ARMY	124		6,156.63
	MARINE	17		1,341.25
	NAVY	96		3,714.13
	NAVY & MC	113		5,055.38
	AIR FORCE	85		2,817.20
	PHS	4		99.89
	VET ADMIN	34		1,035.07
TOTAL FY 75		360		15,364.17
	TOTAL STATE	438		17,587.80

EARLIEST DATE OF CARE 72 02

LATEST DATE OF CARE 75 03

EXHIBIT 20
VOUCHER PRINTOUT

MC14P L03D 24/04/75 PAGE 2

IOWA STATE NO. 14

VOUCHER NUMBER 75-1818 SUMMARY BY BRANCH

FIS. YR.	BR. SV.	CLAIMS	HOS. DAYS	AMT. DUE GOVT.
9750100.6300	63-1303	P6300-2572	FIC 630000.12000.000	SO5114
7.50 X ARMY		167		1,252.50
7.50 X NAVY & MC		126		945.00
7.50 X AIR FORCE		105		787.50
7.50 X PHS		4		30.00
7.50 X VET ADMIN		36		270.00
7.50 TOTAL STATE		438		3,285.00

COMBINED PROFESSIONAL & ADMIN COSTS FOR VOUCHER FY

ARMY	7,409.13
NAVY & MC	6,000.38
AIR FORCE	3,604.70
PHS	329.89
VET ADMIN	1,305.07
TOTAL ALL BRANCHES	18,649.17

Exhibits 21 and 22 as "Less Deduct Items" is an error which materially affects a claim. The error in this sample occurs in the line entry for the patient named Kalerg. Column T, Amount Paid for Principle Procedure, is shown as $131. The OCHAMPUS Edit Error Program automatically searches the files for a determination of which figure is correct and calculates the correct amount, in this case $64.80.

A "Soft" edit error, on the other hand, does not materially affect the claim. Examples of soft errors are shown in Exhibit 23. This sample soft edit error list is taken from a physician's claims tape. The code "37 I" is defined as an invalid procedure code in Column R. Exhibit 24, the legend for Physician's Records, is included to permit easier reading of Exhibits 22 and 23.

All edit errors are returned to the contractor for correction via a standard form letter which explains the effect of hard and soft errors and contains direction to the contractor on procedures to follow in correcting and resubmitting the error claims. This form letter is shown in Exhibit 25. It should be noted that less than 10 percent of all claims that are processed by OCHAMPUS result in an edit error list.

After the processed Voucher Listings have been compared with the Control Listings, a voucher clerk prepares a CHAMPUS Form 197, Contractor Reimbursement Worksheet. This form is shown in Exhibit 26. The Voucher Number block may contain more than one Voucher Number, but each number can be readily

EXHIBIT 21

MC50H

EDIT ERROR LIST FOR 02 VOUCHER
VOUCHER = 751919 INVOICE = 000609

DAY MO YR
16/04/75

VOUCHER TOTALS	GOVT COST BILLED	62,194.19	CLAIMS BILLED	937
	LESS DEDUCT ITEMS	64.80	CLAIMS DEDUCT	1
	TOTAL REIMBURSEMENT	62,129.39	TOTAL CLAIMS	936

EXHIBIT 22

MC50H

EDIT ERROR LIST FOR 02 PHYSICIAN
VOUCHER = 751919 INVOICE = 000609

DAY MO YR
16/04/75

A	BC	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R	S	T	U	V	W	X	Y	Z
HARVEY	B	35	1	3	456543443 37 I	2	1			722	02	56945	72	25	610	00421	00	0045	0045	0045	00900	003600	000000	7
JAEGER	JA	25	1	3	117424244 37 I	2	1			722	02	56945	72	94	233	00421	00	0045	0045	0045	00900	003600	000000	7
HARRIS	SJ	25	1	3	406749774 37 I	2	1			720	02	2	72	84	796	07421	00	0045	0045	0110	02200	000000	008800	7
ERVIN	HL	68	4		440321945 04 O	4	2	1		729	02	56797	72	25	401	09000	02	0011	0011	0029	00725	002175	000000	P
PLYLER	JA	69	1		432662774 04 O	1	2	1		729	02	2	72	44	692	09000	02	0011	0011	0020	00492	000000	001475	P
STRAIN	P	65	1		356038782 04 O	2	2	1		720	02	2	72	25	847	09028	00	0007	0007	0101	02525	000000	007575	P
KALERG	RJ	27	1	3	512386837 32 R	1	3			717	02	10067	73	15	796	09099	00	0031	0131	0131	06620	006480	000000	7

PROCEDURE CODE 99200 CLAIM COUNT 0

PROGRAM TOTALS

GOVT COST BILLED	56,798.90	CLAIMS BILLED	768
LESS DEDUCT ITEMS	64.80	CLAIMS DEDUCT	1
TOTAL REIMBURSEMENT	56,734.10	TOTAL CLAIMS	767

EXHIBIT 23

PC50H — EDIT ERROR LIST FOR 14 PHYSICIAN — DAY PC YR — PAGE 00009
VOUCHER = 751810 INVOICE = 000216 — 01/04/75

A	BC	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R	S	T	U	V	W	X	Y	Z	1
KENT	HL	01	3	1	253663435 37 I	1	1			515	14	004466	C1	15	485	0022C	C0	C03C	0030	0110	00000	011000	000000	7	
JEBSEN	RR	22	1	1	478727983 37 I	1	1			527	14	006862	C1	84	3CC	00220	C0	CC25	0025	0712	00000	071200	000000	7	
JESS	TA	02	3	1	478622803 37 I	1	1			514	14	0013C0	C1	25	CC5	00220	00	CC25	0025	0122	00000	012200	000000	7	
HOLLIC	MJ	16	3	2	478341375 37 I	2	2	1	503	14	005893	C1	54	945	00222	C0	C25C	0250	0925	23125	000000	069375	7		
CARPEN	SP	39	1	2	230241801 37 I	4	2	1	502	14	005893	C1	84	47C	00250	C0	C155	0155	0155	03875	000000	011625	7		
HOLLEY	BK	18	1	1	478687885 37 I	4	1			506	14	006433	C1	64	595	00250	C0	C061	0061	0061	00000	006075	000000	7	
FORTIE	RC	45	4		526308709 37 I	2	2	1	501	14	001180	C1	64	432	00250	C0	CC6C	0060	0160	04000	012000	000000	7		
CHRIST	FA	39	1	2	485328287 37 I	4	1			522	14	002455	C1	25	425	00250	C0	C050	0050	0050	00000	005000	000000	7	
STEVEN	DE	35	1	1	483520846 37 I	1	1			526	14	001464	C4	42	5CC	00250	00	CC35	0035	0035	00000	003500	000000	7	
SIRCAE	DE	03	2	3	C03323514 37 I	1	1			528	14	06C1C4	73	15	92C	00250	C1	C043	0043	0068	03920	002880	000000	7	
ROBERT	MC	00	2	2	484680167 37 I	1	1			525	14	005137	C1	64	62C	00285	C0	CC3C	0030	0030	00000	003000	000000	7	
KLEIN	JM	CC	3	1	481464862 37 I	4	1			52C	14	0016C8	C1	15	62C	00285	C0	CC25	0025	0025	00000	002500	000000	7	
WEBSTE	AC	00	2	1	481748192 37 I	4	1			511	14	005525	C1	25	62C	00285	C0	CC25	0025	0025	00000	002500	000000	7	
PARCUA	CD	00	3	1	399505533 37 I	2	1			527	14	006854	C1	24	62C	00285	00	CC25	0025	0025	00000	002500	000000	7	
CULMAN	GE	16	3		484348024 37 I	4	2	1	506	14	001888	51	15	CC9	00600	C5	C01C	0010	0037	00925	002775	000000	7		
RUBNER	CR	37	1	2	481464342 37 I	1	1			505	14	005893	51	-4	62C	00600	C2	CC25	0025	0040	00080	000000	003120	7	
SLOAN	WE	63	4		484326762 37 I	4	2	2	503	14	003614	04	-4	532	00610	C0	C075	0075	0075	01875	005625	000000	7		

EXHIBIT 25

DEPARTMENT OF DEFENSE
OFFICE FOR THE CIVILIAN HEALTH AND MEDICAL PROGRAM OF THE UNIFORMED SERVICES
DENVER, COLORADO 80240

CH. 19

RE: OCHAMPUS Voucher #

Dear

Inclosed is a machine listing of rejected and unrejected (hard and soft) errors found by the application of the OCHAMPUS Editing Procedures as outlined in the appropriate Appendix, as revised.

Rejected (hard) errors have been deleted from payment of your Invoice No._____ as indicated:

STATE	CLAIMS			AMOUNTS		
	PHYS	DRUG	HDCP	PHYS	DRUG	HDCP

Please correct these rejected records and resubmit them on a future invoice. Do not resubmit these records as adjustments, since a claim rate has not been paid for these rejected claims.

Unrejected (soft) errors may also appear on the attached list. These records have not been rejected, but require correction. Please correct these records and resubmit them on a future invoice as adjustments. It is important that these soft errors be resubmitted as adjustments, since a claim rate has already been paid on these unrejected claims. Unrejected claims may include credit items. Credit items will never delete as hard errors, since a credit deletion could result in a voucher total greater than the invoiced amount.

Sincerely,

Incl.
Error Edit Listing

REBA B. RANSOM
Chief, Finance and Accounting Division

EXHIBIT 26

CONTRACTOR REIMBURSEMENT WORKSHEET – PROFESSIONAL COST LIQUIDATION & ADMINISTRATIVE COSTS

1. VOUCHER NO.

2. MAKE PAYABLE TO:

3. PP#			
		Certified Invoice Attached Certified Invoice Attached Certified Invoice Attached	$
		(For Period _____ thru _____) For Payment to Civilian Sources for Health and Medical Benefits (_____ Claims)	
		Certified Invoice Attached Certified Invoice Attached Certified Invoice Attached	
		Claims at $ _____ each	
			$
		Less _____ PP No. _____ (Vou No. _____) dtd _____ Less _____ PP No. _____ (Vou No. _____) dtd _____ Less _____ PP No. _____ (Vou No. _____) dtd _____ Less _____ PP No. _____ (Vou No. _____) dtd _____	
		21 42020 06–6030 P840900-2572 (FIC 841214.12100.199) SO5114 Army.	
		Amount Verified	$

CHAMPUS FORM 197 AUG 73

traced back to the original request for advancement of funds. To explain further, refer to the Voucher Number 75-1818 on previous exhibits and in the discussion above. When the SF 1034 was prepared for the advance funds, this number appeared as 75-1818(I). On the Voucher Transmittal and on the Form 197 now being prepared the number appears as 75-1818(II). If one assumes that the invoice contained the Hard Edit Error in Exhibit 22, the same Voucher Number will appear on another Form 197 as 75-1818(III) when the edit error is resubmitted for payment. Another method of cross-reference on the Form 197 is the block labeled "PP#" in which the partial payment number from the funds advanced voucher and the Routing and Transmittal Slip is entered.

Within the main portion of the Form 197 the top three entries titled "Certified Invoices Attached" are suffixed by a letter - P, D, H, etc. - depending on whether the category of claims is for Physicians, Drugs, Hospital, or so forth. The dollar amounts of the claims are entered in the dollar column. Deduct items from Hard Edit Errors are subtracted from the claims costs to arrive at a net total of professional costs.

The "Certified Invoices Attached" section in the middle of the form is used to account for administrative costs as computed on the Summary by Branch section of the Voucher Listing shown in Exhibit 20, above. As in the professional costs section of the form, deductions for Hard Edit Error

claims are made, that is, the claim rate times the number of rejected claims is deducted from the total administrative costs shown on the Summary by Branch.

C. ACCOUNTING PROCEDURES

After CHAMPUS Form 197 is completed, it is sent to an accounting technician who verifies the figures against ledger entries for the advancement of funds. This particular procedure is time consuming as the accounts are listed by Fiscal Year, by Professional Cost categories, by Administrative Cost categories, and by Direct and Indirect Cost categories for each branch of service. These accounts are listed on an accounting sheet which is approximately 48 inches long. All entries on this spread sheet are made manually and all columns must be totaled, balanced, and cross footed daily.

When the above procedures are completed, the information is posted to a Miscellaneous Obligation Document, DA Form 3717. This form is shown in Exhibit 27. The date used on this form is the next working day's date. The description is a four digit internally generated code representing the branch of service. The codes currently in use are:

ARMY - 6025	PHS - 6028
NAVY - 6026	VET ADMIN - 6029
AIR FORCE - 6027	

Column 3 is the amount in the appropriation for the branch of service, column 6 is the total disbursed for that day, and column 7 is the unliquidated balance of the appropriation.

EXHIBIT 27

MISCELLANEOUS OBLIGATION DOCUMENT FOR USE OF THIS FORM, SEE AR 37-108, THE PROPONENT AGENCY IS OFFICE OF THE COMPTROLLER OF THE ARMY.	*Use reverse side for continuation of partial payment record.*	MISCELLANEOUS OBLIGATION DOCU NR	DATE PREPARED
INSTALLATION	ACCOUNTING CLASSIFICATION		
	APPROVED BY		
PREPARED BY *(Signature and title)*			

DESCRIPTION	AMOUNT

PARTIAL PAYMENT RECORD		NAME OF VENDOR OR CONTRACTOR			CONTRACT OR PURCHASE ORDER NUMBER	
DATE 1	DESCRIPTION 2	OBLIGATION 3	ACCRUED EXPENDITURE 4	ACCOUNTS PAYABLE BALANCE 5	DISBURSEMENT 6	*(Check appropriate box)* ☐ UNLIQUIDATED ☐ UNDELIVERED BALANCE 7

The sum of the figures in columns 6 and 7 must equal the balance shown in column 3.

The process is completed when the above data is entered into the computer from the appropriate Accounting Coding Sheet, a form used primarily for the computer keypunch section. At the end of each month all accounting reports generated by the computer are checked against the accounts in the several ledgers and manually balanced against the FAMC Disbursing Officer's Report. In case of differences the Disbursing Officer's Report is considered the correct figure. In order not to have to go back through the 400 plus vouchers processed in an average month, the Disbursing Officer furnishes OCHAMPUS with a daily Disbursing Officer's Report. An additional check is made to make certain that the ledger figures are what was actually fed into the OCHAMPUS computer.

The Finance and Accounting Division receives at the end of each month all of the usual accounting reports, such as the Trial Balance of Accounts, a Consolidated Allotment Report, a Status of Funds Report, a Status of Reimbursements Report, a Current Month's Disbursements Report, a Cumulative Disbursements Reports, and a Report of Unliquidated Obligations. The Status of Reimbursements Report pertains to funds owed to OCHAMPUS by the Public Health Service and the Veterans Administration for which direct reimbursement authority was received from the Secretary of Defense at the time the approved budget for OCHAMPUS was received. These funds are

billed to the respective agencies for the amount of professional claims costs and administrative costs on a monthly basis. A Standard Form 1080, shown in Exhibit 28, is used for these billings. Because there is the direct reimbursement authority, the agencies are not required to issue a Reimbursable Work Order or other similar document as is required in nearly all other reimbursable instances.

The Finance and Accounting Division also receives one special report each month. This is the Finance and Accounting Distribution List. This report provides the professional claims costs by category of claim, by administrative costs, by direct and indirect costs for each branch of service by fiscal year and by state. Thus, they can cite, for example, that the total costs for Fiscal Year 1974 for Physician's claims and other costs that were incurred by Navy beneficiaries in the State of Florida amounted to $1,111.23, or whatever the true sum might be.

EXHIBIT 28

Standard Form 1080
Revised May 1970
2 Treasury FRM 2500
1080-108-83

VOUCHER FOR TRANSFERS BETWEEN APPROPRIATIONS AND/OR FUNDS

VOUCHER NO.

SCHEDULE NO.

BILL NO.

Department, establishment, bureau, or office billing

PAID BY

Department, establishment, bureau, or office billed

ORDER NO.	DATE OF DELIVERY	ARTICLES OR SERVICES	QUANTITY	UNIT PRICE COST	UNIT PRICE PER	AMOUNT DOLLARS AND CENTS
					TOTAL,	

Remittance in payment hereof should be sent to—

ACCOUNTING CLASSIFICATION—*Billing Office*

Appropriation Symbol and Subhead	Object Class	Bureau Cont. and Suballot. No.	Auth. Accig. Activity	T Y P E	Property Accig. Activity	Cost Code	Amount

CERTIFICATE OF OFFICE BILLED

I certify that the above articles were received and accepted or the services performed as stated and should be charged to the appropriation(s) and/or fund(s) as indicated below; or that the advance payment requested is approved and should be paid as indicated.

(Authorized administrative or certifying officer)

(Date)

(Title)

ACCOUNTING CLASSIFICATION—*Office Billed*

Paid by Check No.

VI. THE CHAMPUS BUDGETING PROCESS

A review of Hearing Reports of the Senate and House of Representatives Appropriations Committees enables one to obtain the Department of Defense budgeted cost figures for the CHAMPUS Program for several consecutive years. One should not think, however, that by aggregating these cost submissions that the total program costs can be obtained. By law the CHAMPUS Program is for the dependents of the uniformed services. The definition of uniformed services is written to include the personnel of the Air Force, the Army, the Navy, the Marine Corps, the Coast Guard, the Commissioned Corps of the National Oceanic and Atmospheric Administration, and the Commissioned Corps of the U. S. Public Health Service. The budgets of the Uniformed Services other than those of the Defense Department are to be found in the various other departmental budgets considered by Congress. The combined budgets of the Coast Guard, the Commissioned Corps of the National Oceanic and Atmospheric Administration and the Commissioned Corps of the U. S. Public Health Service comprise about 3.5 percent of the total CHAMPUS budget. These budgets are not readily available and are not explicitly considered in this chapter.

In addition, in 1974, the Veterans Administration requested and received permission to establish a CHAMPUS-type program for its beneficiaries. Their program, commonly called CHAMPVA, is a separate program from CHAMPUS operating

through Regional VA offices in the OCHAMPUS framework. Their program uses the OCHAMPUS forms and follows the OCHAMPUS policies and claims processing procedures. The OCHAMPUS contractors do the actual claims processing for the Veterans Administration. OCHAMPUS acts primarily as a disbursing agent in the reimbursement of the contractors for professional services provided to VA beneficiaries. While it is assumed that the Veterans Administration does budget for the costs involved in their CHAMPVA Program, its budget is also not readily obtainable and is not explicitly considered in this chapter.

In their budget submissions each of the three branches of the Defense Department presents the budgeted costs in a slightly different manner. Prior to Fiscal Year 1975 the individual branches budgeted for the CHAMPUS Program as a part of Program 8 - Training, Medical, and Other General Personnel Activities of their respective Operations and Maintenance Appropriation Budgets. Appendices B, C, and D are the Fiscal Year 1974 budget submissions for the Army, the Navy, and the Air Force, respectively, for the CHAMPUS Program. These budget submissions were extracted from the total service O&M budget for each branch of service and are presented to demonstrate the variations in budget submission format.

In spite of the slightly different forms of budget submission it is relatively easy to pick out the program costs.

Table I presents the Department of Defense CHAMPUS budget submission figures for Fiscal Years 1968 to 1974. In several budget years the submitted cost estimates were not valid. For example, estimate #1, Fiscal Year 1972, is the estimated program costs in the original Presidential Budget. Estimate #2 is the amount that the service chiefs testified to as the true needs of the program in the House of Representatives hearings. Estimate #3 is from the service chief's testimony at the Senate Appropriation hearings. Appendix E, a verbatim excerpt from Fiscal Year 1974's House of Representatives Appropriations hearings on the Army O&M Budget, illustrates that an estimate cost may not really be an estimated cost [Ref. 65]. This type of testimony is not uncommon in the Department of Defense budget hearings. In most years, CHAMPUS cost testimony is limited to trite questions of what the program is and who is eligible for what type of benefits. Usually, the questioner merely asks that such information be supplied for the record.

In the Senate Appropriation hearings for Fiscal Year 1973, Senator Allen Ellender, Chairman of the Senate Committee on Appropriations, stated, "I see no reason to get into medical care in non-service facilities since you have nothing to do about it except pay the bills [Ref. 66]." And that was the total mention of the OCHAMPUS Program costs in the Senate for that year. Thus, one is led to the conclusion that the budgeted CHAMPUS costs that are approved by Congress are

TABLE I

DEPARTMENT OF DEFENSE BUDGET SUBMISSIONS FOR CHAMPUS PROGRAM
FOR FISCAL YEARS 1967 TO 1974
($ IN THOUSANDS)

FISCAL YEAR	OCHAMPUS	ARMY	NAVY	AIR FORCE	TOTAL[1]
1967 (Actual)	($ 627)	($38,508)	($55,058)	($28,685)	($122,878)
1968 Est	1,400	75,903	63,031	38,336	178,670
(Actual)	(1,400)*	(59,306)	(55,892)	(37,182)	(153,780)
1969 Est	1,600	73,386	58,619	39,339	172,944
(Actual)	(1,600)*	(73,373)	(66,995)	(50,287)	(192,246)
1970 Est	1,500	78,997	78,814	57,761	217,072
(Actual)	(1,343)	(97,359)	(94,438)	(64,886)	(258,026)
1971 Est #1	1,600	76,900	90,499	69,536	238,535
Est #2	1,601	124,200	91,959	71,178	288,938
(Actual)	(1,601)*	(103,462)	(123,937)	(82,886)	(311,886)
1972 Est #1	1,615	87,604	92,595	73,693	255,507
Est #2	1,615 *	139,562	94,983	120,492	356,652
Est #3	1,615 *	140,600	124,147	139,771	406,133
(Actual)	(2,000)	(139,367)	(129,361)	(118,784)	(389,512)
1973 Est #1	1,831	155,029	144,684	136,721	438,265
Est #2	2,000	155,069	155,562	143,286	455,748
Est #3	2,013	176,542	159,003	155,548	493,106
(Actual)	(Not Available)				
1974 Est #1	1,977	204,650	178,447	201,735	586,809

[1]Total does not include the US Public Health Service budget submission. The USPHS would increase above figures by approximately 2.5%.

* - No reported figures in Congressional Hearing Reports. Figures shown represent preceding budget submission.

Figures in parenthesis labeled actual represent total program costs as reported by the Department of Defense to Congress in the Congressional Budget Justification Book. Actual program costs shown are normally reported two years after the end of the fiscal year. For example, FY 1967 actual figures first reported in FY 1969 budget submission.

TABLE I (CONTINUED)

Source: Reported Hearings, House of Representatives and U. S. Senate Committees on Appropriations and their respective Subcommittees on Defense Appropriations, Hearings on Operation and Maintenance Budgets, Fiscal Years 1968 to 1974.

whatever figure of the branches of the Armed Forces say is needed. In Table I the figures listed as "actual" are not to be considered as the final DOD costs of the program. These figures are the ones that are reported to Congress as being the actual costs incurred for that year by the branches of the Armed Forces. It should be noted that in nearly every year the reported actual costs exceeded the budget estimates for that year. It should also be noted that the "actual costs" are obtained from the budget submissions two years after a dollar amount is approved by Congress. To explain further, the "actual" costs shown for FY 72 in Appendices B, C and D are first reported in the FY 74 budget. The FY 73 budget would have reported FY 71 costs as actual and the FY 72 and FY 73 costs as estimated.

An initial step in analyzing these budget submissions was to determine the percentage composition of the total CHAMPUS budget. To do this the total CHAMPUS costs, both budgeted and actual reported costs were summed. This figure was then considered as the total cost figure for that year. Then the respective figures submitted by the individual branches of the Armed Forces were used to determine their percentage share of the budget. Table II shows the results of these calculations. In order to more accurately present the percentage share of each year's budget and reported costs the estimated and reported costs of operations at OCHAMPUS

TABLE II

DEPARTMENT OF DEFENSE BUDGET SUBMISSIONS FOR CHAMPUS PROGRAM FOR FISCAL YEARS 1967 TO 1974

PERCENTAGE COMPARISONS*

FISCAL YEAR	OCHAMPUS	ARMY	NAVY	AIR FORCE
1967 Actual	0.5	31.4	44.8	23.3
1968 Est.	0.8	42.5	35.3	21.5
Actual	0.9	38.6	36.3	24.2
1969 Est.	0.9	42.4	33.9	22.8
Actual	0.8	38.2	34.8	26.2
1970 Est.	0.7	36.4	36.3	26.6
Actual	0.5	37.7	36.6	25.2
1971 Est. #1	0.7	32.2	37.9	29.2
Est. #2	0.6	43.0	31.8	24.6
Actual	0.5	33.2	39.7	26.6
1972 Est. #1	0.6	34.3	36.3	28.8
Est. #2	0.5	39.1	26.6	33.8
Est. #3	0.4	34.6	30.6	34.4
Actual	0.5	35.8	33.2	30.5
1973 Est. #1	0.4	35.4	33.0	31.2
Est. #2	0.4	34.0	34.2	31.4
Est. #3	0.4	35.8	32.3	31.5
1974 Est. #1	0.3	34.9	30.4	34.4

* All numbers expressed as a percentage.

were considered as a separate entity. These costs were normally submitted as part of the Army's budget.

In reading Table II there seems to be two trends. First, the OCHAMPUS operations costs seem to be decreasing as an overall percentage of the budget. Second, it appears that the Air Force, in the last three of the years considered, has considerably increased its percentage share of the program's costs. It must be cautioned that Table I and Table II should be read in conjunction with one another. For example, the Air Force has increased its share of the program costs by about 10 percent but its actual dollar amount of increased costs in Fiscal Year 1974's estimate is more than seven times the amount reported as actual costs in Fiscal Year 1967.

A. NAVY'S CHAMPUS BUDGETING PROCESS

Prior to Fiscal Year 1976 the Bureau of Medicine and Surgery (BUMED) was responsible for the development of the CHAMPUS budget [Ref. 67]. They prepared the preliminary figures and forwarded them to the Comptroller of the Navy (NAVCOMPT) for consolidation with other Operation and Maintenance, Program 8 budgets. In July 1974, BUMED began preparation of its submission of the Fiscal Year 1976 budget. At that time they had a copy of the May 1974 CHAMPUS Phaseback Data (to be discussed in later section) and advance inpatient care information for June 1974. This information was used to develop a straight line projection which was used as the starting point for the NAVCOMPT 76 submission.

A straight line projection is an extrapolation of what is going to happen in the future based upon historical data. The CHAMPUS Program estimate for a given fiscal year is projected through the thirty-sixth month of the program by applying the rate of change of the most recent past year's actual experience to the latest monthly figures for the fiscal year being projected. This projection method assumes that the fiscal year program being projected will change in direct proportion to the most recent past year's experience. The projections are made for inpatient and outpatient workload and inpatient cost per day and outpatient cost per visit for the categories of inpatient, outpatient medical and outpatient psychotherapy.

To compute drugs, retarded and handicapped, and dental, the prior ratio of change is computed using total obligations experience. The ratio is then applied to the latest month's recorded obligations in order to project the total funding requirements for these three program categories. Table III illustrates the use of the straight line projection technique for the inpatient category as it was used in BUMED's NAVCOMPT 76 submission. Table IV illustrates the outpatient categories projections. These straight line projections are used as the basic starting point for completing the NAVCOMPT Submit. This base year is then adjusted for anticipated physician shortage, closure of hospitals, and contractor backlog to derive the FY 74 estimate. It would seem that the purpose of the

TABLE III

STRAIGHT LINE PROJECTIONS INPATIENT

A	B	C	D
2ND YR JUNE FY 73 ÷	1ST YR. JUNE FY 73 x	1ST YR. JUNE FY 74 =	2ND YR JUNE FY 74
ACTIVE DUTY DEPENDENTS ADPL			
1622	1268	1146	1466
RETIRED DEPENDENTS ADPL			
1290	939	920	1264
RETIRED ADPL			
335	239	261	366

E	F	D	Y
3RD YR JUNE FY 72 ÷	2ND YR JUNE FY 72 x	2ND YR JUNE FY 74 =	3RD YR JUNE FY 74
ACTIVE DUTY DEPENDENTS ADPL			
1521	1513	1466	1474
RETIRED DEPENDENTS ADPL			
1159	1143	1264	1282
RETIRED ADPL			
325	321	366	371

TABLE IV

STRAIGHT LINE PROJECTIONS OUTPATIENT

2ND YR MAY FY 73	÷	1ST YR MAY FY 73	X	1ST YR MAY FY 74	=	2ND YR MAY FY 74	3RD YR MAY FY 72	÷	2ND YR MAY FY 72	X	2ND YR MAY FY 74	=	3RD YR MAY FY 74+	DIFF MAY JUNE FY72	=	JUNE FY 74
DEPENDENTS OF ACTIVE DUTY OTHER THAN PSYC. ADPL																
586		297		299		590	386		375		590		607	1		608
RETIRED DEPENDENTS OTHER THAN PSYC. ADPL																
946		427		444		984	1145		1122		984		1004	1		1005
OUTPATIENT RETIRED, ADPL, OTHER THAN PSYC.																
239		110		120		261	238		232		261		268	0		268
DEPENDENTS OF ACTIVE DUTY, PSYCHOTHERAPY																
355		174		344		702	210		206		702		715	0		715
RETIRED DEPENDENTS, PSYCHOTHERAPY																
244		124		213		419	377		373		419		423	0		423
RETIRED PSYCHOTHERAPY																
46		24		48		92	47		46		92		94	0		94

adjustment is to enable one to more accurately estimate the told costs for the base year. It should be noted that the information available to BUMED at the time (June-July 1974) provided cost data for twelve months. This data had to be projected forward for an additional twenty-four months and in order to make the projection as accurate as possible, the various adjustments had to be computed and added to the original projections. The adjusted FY 74 estimate is then used to make the projections for the FY 75 estimate.

To project the Average Daily Patients (ADP) for Fiscal Year 1975 the ADP estimate for Fiscal Year 1974 was divided by the Fiscal Year 1974 population to get a hospital rate. This rate was then applied to estimated Fiscal Year 1975 population to obtain the Fiscal Year 75 ADP estimate. The estimate was then "adjusted" for physician shortages, hospital closures, new hospital services additions - specifically the addition of OB-GYN service at Naval Hospital, Long Beach - and contractor backlogs to derive an adjusted estimate for Fiscal Year 1975. The comments above pertaining to the purpose of the adjustments should be kept in mind.

On 17 July 1974 BUMED budget officers obtained the following backlog information from OCHAMPUS:

CLAIMS ON HAND	74	73	DIFF.
Mutual of Omaha	17,734	11,184	+6,550
Blue Cross/Blue Shield	13,583	13,864	- 281
Fiscal Year 73 Backlog			6,269

The number of backlog CHAMPUS claims is then multiplied by the average Length of Patient Stay (LOPS) taken from the latest available Quarterly Statistical CHAMPUS Summary, in this case the March 1974 SUMMARY, to obtain the Tri-Service Hospital Days:

Backlog Claims	6,269
Average LOPS	8.2
Tri-Service Hospital Days	51,406

The Navy's portion of the backlogged claims was then computed by dividing the number of actual Navy and Marine Corps claims from Mutual of Omaha by the total number of CHAMPUS claims for the states covered by contract with Mutual, then multiplying the percentage by the above figure:

37,100 / 103,200 = 35.9% (Navy's Percentage Share)

51,406 X 35.9% = 18,455 Navy Hospital Days

Using data in the June 1974 CHAMPUS Phaseback Data the percentage of actual Hospital Days Claimed by the three patient categories was computed. These percentages were then applied to the Navy Backlogged Hospital Days Claimed to obtain the Hospital Days Backlog by Patient Category for the Navy:

DEP A/D	DEP RET/DEC	RETIRED
18,455	18,455	18,455
49.2%	39.5%	11.3%
9,080	7,290	2,085

Using the figures just computed, the Hospital Days Claimed by Patient Category in the June Phaseback Data were increased by 9,080, 7,290 and 2,085 respectively. Using the new totals

a new straight line projection computation was made. The result was the estimated ADP for Fiscal Year 1975.

The next step in the budget development was to calculate the various adjustment factors. The Naval Hospital, Boston, was closed in June 1974. In reviewing monthly reports in BUMED it was observed that the Average Daily Patient Load for this hospital had been relatively stable from July 1973 to March 1974. Reports for April and May of 1974 showed a marked drop in the ADPL. The computations used by BUMED to show the effect of the closure on the CHAMPUS Program are as follows:

1. ADPL Retired.

Jul-Mar: 9 month ADPL	192 / 9 =	21.33
FY 74; 12 month ADPL	208 /12 =	17.33
Effect is FY 74 adjustment to CHAMPUS		+4.0

2. ADPL Retired Dependents.

Jul-Mar: 9 month ADPL	111 / 9 =	12.33
FY 74: 12 month ADPL	119/12 =	9.92
Effect is FY 74 adjustment to CHAMPUS		+3.0 (Rounded)

It would seem that the total number of patients in each of the two categories were divided by the nine and twelve month factor to obtain the Average Daily Patient Loads. That is, for retired persons there were 192 admissions in nine months of the year and only 16 in the last three months (actually only two months as the hospital was closed in June, the last month of the fiscal year). It is not clear why the twelve month ADPL was subtracted from the nine month ADPL and

the difference termed the "Effect" of an adjustment to CHAMPUS. It is thought that this difference might pertain to the phenomenon that not all persons who could have used the Naval Hospital would now use CHAMPUS. That is, some of these patients would journey to other military hospitals and some would not receive hospitalization but would have their problem treated on an outpatient basis. There was no indication in data received from BUMED as to the effect the hospital closure would have on the dependents of active duty personnel.

In July 1974, BUMED's conservative estimates were that Naval Hospitals and Naval Regional Medical Centers would lose over 400 physicians by the end of July. A decrease of patient care delivery capability had already been felt in May and June. In those months, BUMED believed that a shift to CHAMPUS of approximately 2.0 percent had occurred. Using the ADPL data for May and June this shift was translated into an ADPL of approximately 142. The full year impact was computed by multiplying the patient category percentages for May and June, computed as the percentage of actual Hospital Days Claimed by the three patient categories, by 24 to obtain the yearly Adjusted ADPL by Patient Category. There was no explanation as to where the figure "24" was obtained nor as to its significance in the calculations. It is thought that the "24" must be the number of average Patient Days associated with the loss of the 400 physicians. The actual computations used by BUMED are shown below:

Patient Category	Percentage		Yearly Adj. ADPL by Pat. Cat.
Active Duty Dependents	47% X 24	=	11
Retired Dependents	41% X 24	=	10
Retired Members	12% X 24	=	3
Total			24

The calculations used to develop the Fiscal Year 1974 projected inpatient ADPL for the Fiscal Year 1975 Program are shown in the following sections:

1. Active Duty Dependents.

Straight line projection (June)	1,474
Contractor Backlog	43
Navy doctor shortage	9
FY 74 projected ADPL	1,526

2. Retired/Deceased Dependents.

Straight line projection (June)	1,282
Contractor Backlog	30
Boston closure	3
Navy doctor shortage	8
FY 74 projected ADPL	1,323

3. Retired Members.

Straight line projection (June)	371
Contractor backlog	9
Boston closure	4
Navy doctor shortage	2
FY 74 projected ADPL	386

It should be noted that no adjustment was indicated in the FY 75 estimate for active duty dependents which would reflect the effect of closing Naval Hospital, Boston. Further, it must be noted that the Navy doctor shortage figures used in the above calculations do not sum to 24. It is thought that the difference can be attributed to the fact that some patients would be treated at other military facilities

(other services or PHS) and that some care would be received in an outpatient status versus an inpatient status. Another possible explanation would be that the original figures of 11, 10, and 3 were subjected to some type of straight line projection and were thus reduced to the figure shown.

It should be remembered that the above calculations are presented to demonstrate the techniques used by BUMED in developing the CHAMPUS Program budget. In order to fully understand the import behind the figures it would be necessary to have all of the base data available. This data was not made available and thus no further comment or explanation of the meaning of the above numbers can be made.

An adjustment to the straight line projection in the medical outpatient visits category was also required due to the projected shortage of physicians in late Fiscal Year 1974. Most of the patients, forced to use the CHAMPUS Program for the first time late in the fiscal year, will be subject to the $50 and $100 deductible provisions. Thus, the impact on CHAMPUS would be minimized. BUMED anticipated that the physician shortage would have about a one percent impact on CHAMPUS outpatient visits. This translated into about 230 visits per day for the last sixty-one days of the fiscal year. The May and June actual percentage by patient category of outpatient visits claimed was computed from the Phaseback Data. The effect of the physician shortage on outpatient visits was then computed as shown in the following sections:

1. Medical Outpatient.

Active Duty Dependents	32% X 230 =	74
Retired/Deceased Dependents	53% X 230 =	122
Retired Members	15% X 230 =	34
		230

2. Conversion to Yearly Impact.

Active Duty Dependents	74 / 6 =	12
Retired/Deceased Dependents	122 / 6 =	20
Retired Members	34 / 6 =	6
		38

3. Computation of Total Visits with Adjustments.

Patient Category	May Straight Line	Adj.	Totals
Active Duty Dependents	608	+ 12	= 620
Ret/Dec Dependents	1,005	+ 20	= 1,025
Retired Members	268	+ 6	= 274
		38	1,919

The same procedures were used to project the ADP for Fiscal Year 1976 as were used for Fiscal Year 1975 projections except that the Fiscal Year 1976 projected population and adjustments were used. These computations and adjustment calculations are shown, without explanation, in the following sections:

1. Computations of ADP for FY 76, active duty dependents.

FY 74 Adj. Workload	FY74 + Pop.		FY75 Pop.	FY75 WORKLOAD		OBGYN to LB	
1,507	902,969	X	908,609	= 1,517	-	4	=

Est. Adj. FY75	FY75 Adj. Workload		FY75 Pop.		FY76 Pop.		FY76 Workload
1,513	1,513	+	908,609	X	896,762	=	1,493

2. Computations of ADP for FY 76, retired dependents.

FY74 Adj. Workload	+	FY74 Pop.	X	FY75 Pop.	=	FY75 Workload	+	Boston Close
1,323		824,250		870,088		1,397		10

=	Est. Adj. FY75
	1,407

FY75 Adj. Workload	+	FY75 Pop.	X	FY76 Pop.	=	FY76 Workload
1,407		870,088		909,335		1,470

3. Computations of ADP for FY 76, retired members.

FY74 Adj. Workload	+	FY74 Pop.	X	FY75 Pop.	=	FY75 Workload	+	Boston Close
386		311,754		329,277		408		18

=	Est. Adj. FY 75
	426

FY75 Adj. Workload	+	FY75 Pop.	X	FY76 Pop.	=	FY76 Workload
426		329,277		344,147		455

The following sections demonstrate the calculation of projections of CHAMPUS outpatient visits in the program categories of outpatient care excluding psychotherapy and outpatient psychotherapy care.

1. Active Duty Dependents.

	Outpatient	Psychotherapy	Population
FY 1974 Estimate	620	715	902,969
OB-GYN Addition, LB	34		
Pgm Red		-340	
FY 1974 Adjusted	586	375	
FY 1975 Estimate	590	378	908,609
OB-GYN Addition, LB	- 7		
FY 1975 Adjusted	583	378	
FY 1976 Estimate	575	373	896,762

2. Retired/Deceased Dependents.

	Outpatient	Psychotherapy	Population
FY 1974 Estimate	1,025	423	824,250
Boston Closure	54		
Pgm Red	8	-194	
FY 1974 Adjusted	1,087	229	
FY 1975 Estimate	1,148	242	870,088
FY 1976 Estimate	1,200	253	909,335

3. Retired members.

	Outpatient	Psychotherapy	Population
FY 1974 Estimate	274	94	311,754
Boston Closure	33		
St. Albans	1		
FY 1974 Adjusted	308	94	
FY 1975 Estimate	326	98	329,277
FY 1976 Estimate	341	102	344,147

The cost per day computations were made by taking the average cost per day for twelve months with a four percent inflation add-on for May and June 1974. The Fiscal Year 1975 cost per day reflects a 15 percent inflation increase over Fiscal Year 1974 costs. Budget submission guidelines dictated that Fiscal Year 1976 cost per day calculations were to be held level with those of Fiscal Year 1975. It should be noted that the four percent inflation add-on for May and June 1974 is directly attributable to the removal of price controls at the end of April 1974. The calculations and supporting data for all cost categories of the CHAMPUS Program are shown in the following sections.

1. Inpatient costs for active duty dependents.

May 1974 Phaseback (for FY 1973)		June 1974 Phaseback (for FY 1974)	Percentage Change
July	$122.29	$126.95	3.8
August	124.29	129.40	4.1
September	124.77	136.02	9.0
October	125.71	132.95	5.7
November	120.55	135.57	12.4
December	120.31	126.26	4.9
January	122.74	141.58	15.3
February	122.48	135.83	
March	123.39 + 10.9%	136.84	
April	123.28 + 10.9%	136.72	
May	125.04 + 10.9%	138.67 + 4% (5.55) = 144.22	
June	130.47 + 10.9%	144.69 + 4% (5.79) = 150.48	

The average cost per day without the inflation add-on for May and June 1974 is computed to be $135.12. The average cost per day with the inflation add-on is computed to be $136.07.

2. Inpatient costs for retired/deceased dependents.

May 1974 Phaseback (for FY 1973)		June 1974 Phaseback (for FY 1974)	Percentage Change
July	$ 65.82	$ 70.13	6.5
August	67.02	74.58	11.3
September	65.93	77.08	16.9
October	63.10	76.42	21.1
November	69.19	81.60	17.9
December	65.13	75.95	16.6
January	70.38	81.76	16.2
February	67.14 + 16.9%	78.49	
March	66.34 + 16.9%	77.55	
April	69.33 + 16.9%	81.05	
May	72.09 + 16.9%	84.27 + 4% (3.37) = 87.64	
June	72.39 + 16.9%	84.62 + 4% (3.38) = 88.00	

Without the inflation add-on the average cost per day for this patient category is computed to be $78.63. When the inflation add-on is considered the average cost per day rises to $79.18.

3. Inpatient costs for retired members.

May 1974 Phaseback (for FY 1973)		June 1974 Phaseback (for FY 1974)	Percentage Change
July	$ 75.02	$ 84.87	13.1
August	78.41	86.83	10.7
September	78.45	92.05	17.3
October	68.18	94.31	38.3
November	78.68	95.10	20.9
December	75.37	100.52	33.4
January	79.58	101.04	27.0
February	81.30 + 27%	103.25	
March	78.71 + 27%	99.96	
April	82.13 + 27%	104.31	
May	79.84 + 27%	101.40 + 4% (4.06) = 105.46	
June	85.67 + 27%	107.49 + 4% (4.30) = 111.79	

The average cost per day for this patient category without the inflation add-on is computed to be $97.59. The average cost per day with the inflation add-on is $98.29 per day.

The application of plus-4% per month for the last two months of the Fiscal Year resulted in a basic adjusted inflation factor of 0.007. This factor, when applied to outpatient care resulted in the costs per visit shown below. These costs then reflect the affect of the Wage and Price Guideline removals from the health care industry in April 1974.

	Medical	Psychotherapy
Active Duty Dependents	$18.13	$23.80
Retired/Deceased Dependents	15.86	21.69
Retired Members	19.99	22.34

The baseline figures used in the calculations for inflation effects on outpatient visits were the cost per visit figures which had been calculated on a straight line projection for May 1974. It should be noted that the May 1974 straight line projection for psychotherapy program benefits was

computed using the 1972 trend data because the method of charging visits was changed in March 1973. This change ruined Fiscal Year as a base year for projection purposes. The cost per day could not, therefore, be computed using occurring costs changes based on the Fiscal Year 1973 straight line projection. Thus, the figures shown for Psychotherapy above are computed on straight line projection based on Fiscal Year 1972 trend data.

Drug costs were not inflated by four percent since the additional inflation in 1974 was mainly reflected in direct health care delivery charges. The computations for Fiscal Year 1974 drug costs are straight line projections of Fiscal Year 1973 ($3.193 million) times the inflation rate factor (0.007) for an added cost of $22,000 (total of $3.215 million). For Fiscal Year 1975 a 15 percent inflation rate had been indicated and there was an anticipated population growth factor of slightly over 3.38 percentage. The Fiscal Year 1975 computations used by BUMED were: FY 1974 cost ($2.428 million) plus 3.38% plus the 15% inflation factor for a estimated cost of $2.887 million. For Fiscal Year 1976 no inflation impact was considered because of the budget guidelines; however, a 2.0 percent population growth factor was considered. Thus, the FY 1975 estimate was increased by 2.0 percent for a Fiscal Year 1976 estimate of $2.945 million.

The retarded and handicapped cost category was also not inflated by the 4 percent inflation factor for the reasons

cited above. Using Fiscal Year 1973 straight line projection of $3.193 million times the yearly adjusted inflation factor of 0.007 gives the fiscal year estimate of $3.215 million. In the Fiscal Year 1975 calculations there was an assumption that the Navy would show approximately 30 percent of the planned program reduction of $5.5 million in this cost category. The Navy's share of the reduction amounted to $1.65 million. Thus, using the Fiscal Year 1974 estimate, $3.215 million less $1.650 million results in a figure of $1.565 million. Adding on a 15 percent inflation factor raised the figures to $1.800 million. Consideration of a 3.0 percent population growth factor raised the Fiscal Year 1975 projection to $1.854 million. As in the drug cost computations no inflation factor was considered for the Fiscal Year 1976 projection. A 2.0 percent population growth in dependents of active duty servicemen was considered with the resulting figure for the Fiscal Year 1976 estimate of $1.891 million.

Dental charges were also not inflated by the 4 percent factor. They were inflated by the yearly adjusted inflation factor of 0.007. These computations, using the Fiscal Year 1973 straight line projection of $4.153 million provided a Fiscal Year 1974 estimate of $4.182 million. For Fiscal Year 1975 the Dental Program of CHAMPUS was to be reduced by 90 percent of the Fiscal Year 1973 figure. The Fiscal Year 1973 program total for dental charges was $7.469 million

which, when reduced by 90 percent, results in a Fiscal Year 1975 projection of $0.747 million. For Fiscal Year 1976 it was planned that this program will be fully reduced and discontinued and thus there will be no funding requirement for dental in Fiscal Year 1976.

B. FISCAL YEAR 1976 NAVCOMPT SUBMIT

The final result of all of the foregoing computations is the Fiscal Year 1976 BUMED submission to the Office of the Comptroller of the Navy. The BUMED submission contained all of the budget items relating to the Operation and Maintenace, Navy appropriation, Program 8, Training, Medical, and Other General Personnel Activities for which the Surgeon General of the Navy/Chief of the Bureau of Medicine and Surgery acted as the major claimant. The portion of this NAVCOMPT Submit , whic pertains to the CHAMPUS Program is shown in Exhibit 29A.

As mentioned in an earlier portion of this chapter, the procedures described were in effect prior to Fiscal Year 1975. So, even though the figures shown are for the Fiscal Year 1976 budget, they were not the figures actually used for the FY 1976 CHAMPUS budget. Beginning in Fiscal Year 1975 the Executive Director, OCHAMPUS, prepared an operating budget for the CHAMPUS Program. For that year his input to the budget was based primarily on the guidance received from the us r services. This input guidance was developed, at least for the Navy's input, using the methodology described above.

It should also be noted that, as in previous years, the Army's input guidance contained estimates of the costs for administering the CHAMPUS Program at OCHAMPUS. This budget, part of which is shown in Exhibits 29B, C, and D, was submitted to the Office of the Assistant Secretary of Defense (Health and Environment) for consolidation with other DOD budgets. Congressional action in Fiscal Year 1975 appropriations resulted in a CHAMPUS appropriation of $493 million with a provision that this figure was not to be exceeded during the fiscal year.

In budget submissions for Fiscal Year 1976 the OASD (H&E), the DOD Comptroller and OMB budget guidance directed that the budget would be submitted in accordance with what is termed an "A-11" budget submission [Ref. 68]. This type of budget submission, shown in Exhibits 30, 31, and 32, is more difficult to read and interpret. For example, in Exhibit 30 the Health Related Programs Budget Data, a footnote defines what is included in the term "Other Services." In reading this sheet there is no indication in any entry, nor in the explanation of the costs, to reflect the cost of operating the OCHAMPUS organization. In past years this figure was in excess of $2.5 million. One is forced to conclude that these costs are in some way included in Administrative Costs, a component of Other Services. In previous budgets, the term "Administrative Costs" was applied to those costs budgeted to pay the CHAMPUS contractors for their claims processing costs.

EXHIBIT 29-A

FY 1976 NavCompt Submit

Claimant: SCN
Code: 465
Extension: 254-4340

Department of the Navy
OPERATIONS, NAVY
Program 3 - Program Element/Aggregation 08081 - Medical Care in Non-Service Facilities
($ Thousands)

Section D. (Cont)	Average Daily Patients			Cost Per Day			Total Obligations		
	FY 1974 Estimate	FY 1975 Estimate	FY 1976 Estimate	FY 1974 Estimate	FY 1975 Estimate	FY 1976 Estimate	FY 1974 Estimate	FY 1975 Estimate	FY 1976 Estimate
Contractual Care - CHAMPUS									
Inpatient Care									
Active Duty Dependents	1,526	1,517	1,493	136.07	156.48	156.48	75,790	86,644	85,507
Retired Dependents	1,323	1,407	1,470	79.18	91.06	91.06	38,236	46,764	48,992
Retired Personnel	386	426	445	98.29	113.03	113.03	13,848	17,575	18,409
Cost Sharing Reduction								-8,529	-8,706
Subtotal, Inpatient Care	3,235	3,350	3,408				127,874	142,454	144,202
Outpatient Care									
Active Duty Dependents	620	590	575	18.13	20.85	20.85	4,103	4,490	4,388
Retired Dependents	1,025	1,148	1,200	15.86	18.24	18.24	5,934	7,643	8,011
Retired Personnel	274	326	341	19.99	22.99	22.99	1,999	2,736	2,869
Added Cost Sharing								3,032	3,058
Subtotal, Outpatient Care (excluding pyschotherapy)	1,919	2,064	2,116				12,036	17,901	18,326
Outpatient Care (Psychotherapy)		378	373	23.80	27.37	27.37	6,211	6,776	3,737
Active Duty Dependents	715	242	253	21.69	24.94	24.94	3,349	2,203	2,309
Retired Dependents	423	98	102	22.34	25.69	25.69	767	919	959
Retired Personnel	94								
Reduction for Psychiatric Care									
Sub-total, Outpatient Care (Psychotherapy)	1,232	718	728				10,327	6,898	7,005
							2,428	2,887	2,945
Drugs							3,215	1,854	1,891
Retarded and Handicapped							4,182	747	0
Dental							6,002	6,478	6,539
Contractors' and Services; Other Costs							50	1,300	0
Service Population Estimates							0	359	0
Quality Control Program							166,114	180,878	180,908
Estimated Contractual Care Program Requirements									

EXHIBIT 29-B

COMMANDER'S STATEMENT

1. The FY 1975 Command Operating Budget reflects the guidance received from the Services as of 28 February 1974. Detailed comparisons between the Services' guidance and OCHAMPUS estimates for FY 1974 and FY 1975 are set forth in the two paragraphs which follow. CHAMPVA guidance is not included since this will be furnished by the Veterans Administration.

2. FY 1974	Services' Guidance	OCHAMPUS Estimate
Army	$144,091,000 (a)	$143,573,000 (b)
Navy	162,447,000	167,741,000
Air Force	194,294,000	167,818,000
HHS	12,907,000	12,060,000
TOTAL	$513,739,000	$491,192,000

(a) Includes $2,703,000 for the administrative costs of OCHAMPUS, Denver, Colorado.

(b) Includes $2,703,000 for the administrative costs of OCHAMPUS, Denver, Colorado.

3. FY 1975	Services' Guidance	OCHAMPUS Estimate
Army	$151,693,000 (c)	$152,172,000 (d)
Navy	168,589,000	183,778,000
Air Force	196,250,000	180,001,000
HHS	15,609,000	12,780,000
TOTAL	$532,141,000	$528,731,000

(c) Includes $3,375,000 for OCHAMPUS costs.

(d) Includes $3,400,000 for OCHAMPUS costs.

4. There is an unfinanced requirement of $25,000 for FY 1975. Justification is furnished in Schedule 5.

5. All appropriate Resource Conservation Program actions under the provisions of AR 11-20 have been considered in preparing the FY 1975 COB.

E. R. McCANDLESS
Colonel, MSC, USA
Director

EXHIBIT 29-C

FY 1975 COMMAND OPERATING BUDGET
APPLICATION OF OPERATING RESOURCES
($ In Thousands)

Schedule 1 - OMA

Installation/Activity: Office for the Civilian Health and Medical Program of the Uniformed Services

AMS Account Title: Health Benefits for CHAMPUS Beneficiaries Administered By Executive Director

AMS Account Code: 841214

Code	Description	FY 1973 Actual	FY 1974 6 Months Actual	FY 1974 Total Program	FY 1974 For TSG Use Only	FY 1975 Total Program	FY 1975 For TSG Use Only	Variance Col. 6 vs Col. 4	Unfinanced
	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)
1100	Personnel Compensation	1,145,782	614	1,315		1,474		159	
1200	Personnel Benefits	93,870	51	109		122		13	
2100	Travel and Transportation of Persons	64,681	29	75		75			25
2200	Transportation of Things		1	2				(2)	
2310	Rents	189,901	102	217		217			
2320	Communications	26,168	12	25		25			
2330	Purchased Utilities								
	(TOTAL 2300)	216,069	114	242		242			
2400	Printing and Reproduction	2,800	2	2		2			
2511	Purchased Equipment GOCO/COCO	6,137	6	8		8			
2512	Purchased Equipment Maintenance DOD								
2520	Purchased ADP Services - Outside Government								
2540	Management Studies	97,104							
2550	Operations Research (OR) Studies								

EXHIBIT 29-D

FY 1975 COMMAND OPERATING BUDGET
APPLICATION OF OPERATING RESOURCES
($ In Thousands)

Schedule 1 - OMA

Installation/Activity: Office for the Civilian Health and Medical Program of the Uniformed Services
AMS Account Title: Health Benefits for CHAMPUS Beneficiaries Administered By Executive Director
AMS Account Code: 841214

Code	Description	FY 1973 Actual	FY 1974 6 Months Actual	FY 1974 Total Program	FY 1974 For TSG Use Only	FY 1975 Total Program	FY 1975 For TSG Use Only	FY 1975 Variance Col. 6 vs Col. 4	Unfinanced
	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)
2572	Other Purchased Services	472,213,815*	254,071	511,941		530,171		18,230	
	(TOTAL 2500)	472,317,056*	254,077	511,949		530,179			
2610	Supplies (Excl POL, ADP, Medical and Aircraft)	25,307	17	33		35		2	
2640	Other POL								
2650	ADP Supplies	6,706	3	7		7			
2660	Medical Supplies	39							
	(TOTAL 2600)	32,052	20	40		42		2	
3110	Cap Equipment (Other than Medical & ADP)	988		5		5			
3120	Cap Equipment (Invest)								
3130	Cap Equipment (Expense)								
3140	Cap Equipment Medical Items								
	(TOTAL 3100)	988	3	5		5			
0500	TOTAL OBLIGATIONS	473,873,298*	254,911	513,739		532,141			25
1500	CHANGE IN SELECTED RESOURCES								
4000	TOTAL EXPENSE	473,873,298	254,911	513,739		532,141			25

* Includes $24,052,000 increase over Certified Year end report.

EXHIBIT 30 A-11-45A

DEPARTMENT OF DEFENSE
CIVILIAN HEALTH AND MEDICAL PROGRAM OF THE UNIFORMED SERVICES
OPERATION AND MAINTENANCE - DEFENSE AGENCIES

HEALTH RELATED PROGRAMS - BUDGET DATA
In thousands of dollars)

		Obligations			Outlays		
Category	Code	1974 Actual	1975 Est.	1976 Est.	1974 Actual	1975 Est.	1976 Est.
Provision of hospital and medical services, indirect	16199	1/	493,071	539,141	1/	483,210	528,358
General hospital inpatients	16105		304,067	329,380		298,322	322,792
Psychiatric hospital inpatients	16110		97,199	106,308		95,355	104,182
Outpatient services (other than mental health)	16125		31,633	34,459		30,847	33,770
Outpatient mental health services	16130		22,907	24,953		22,365	22,454
Other services	16135 /2		37,265	44,041		36,321	43,160
Total Health Programs	19999		493,071	539,141		483,210	528,358

1/ Data for the CHAMPUS FY 1974 is included in the 3 Military Department's submissions. Budget responsibilities for the Program were transferred to OASD(H&E) effective with FY 75.

/2 Other services include the following:

	FY 75	FY 76
Program for Handicapped ($000)	11,569	12,695
Administrative costs of operating CHAMPUS	25,696	31,346
Total Other Services	37,265	44,041

EXHIBIT 31 A-11-45B

DEPARTMENT OF DEFENSE
CIVILIAN HEALTH AND MEDICAL PROGRAM OF THE UNIFORMED SERVICES
OPERATION AND MAINTENANCE - DEFENSE AGENCIES

HEALTH RELATED PROGRAMS - WORKLOAD

Category	Code	1974 Actual	1975 Estimated	1976 Estimated
Provision of hospital and medical services, indirect:				
Number of individual in-patients treated	25199	1/	393,110	397,828
Hospitals, general	25105	1/	357,731	362,024
Hospitals, psychiatric	25110	1/	35,379	35,804
Number of other patients treated	25299	1/	576,572	583,491
Outpatients (other than mental health)	25205	1/	455,492	460,958
Outpatient mental health services	25210	1/	121,080	122,533

1/ The data for FY 74 is included in the exhibits prepared by the three military departments.

EXHIBIT 32

DEPARTMENT OF DEFENSE
CIVILIAN HEALTH AND MEDICAL PROGRAM OF THE UNIFORMED SERVICES
OPERATION AND MAINTENANCE - DEFENSE AGENCIES

A-11-45C

HEALTH RELATED PROGRAMS - RECIPIENT CLASSIFICATION
(In thousands of dollars)

		Obligations			Outlays		
		1974	1975	1976	1974	1975	1976
Category	Code	Actual	Est.	Est.	Actual	Est.	Est.
Non-indigent persons, Total	32109	1/	493,071	539,141	1/	483,210	528,358
Aged (65 & over)	32105		---	---		---	---
Other Adults (19-64)	32110		332,872	363,920		326,215	356,642
Children and Youth (0-18)	32115		160,199	175,221		156,986	171,716
Total, all recipients	33199		493,071	539,141		483,210	528,358
Aged (65 & over)	33105		---	---		---	---
Other Adults (19-64)	33110		332,872	363,920		326,215	356,642
Children & Youth (0-18)	33115		160,199	175,221		156,986	171,716

1/ The data for FY 74 is included in the exhibits prepared by the three military departments.

The data in Exhibit 31 is equally confusing. According to the OMB guidelines, the figures should be considered as numbers of persons for each category. The numbers shown, however, cannot be identified with any data recorded in OCHAMPUS. There does not seem to be any way of relating these figures to average daily patient load or numbers of claims, the two main non-dollar reporting categories found in the CHAMPUS data base.

Exhibit 32 is also confusing in that it indicates no persons over the age of 65 have received, or will receive, treatment under the CHAMPUS Program. It is true that at age 65 a person loses his eligibility under the CHAMPUS Program and is then covered by the provisions of the Social Security Administration's MEDICARE Program. There are, however, a substantial number of retired persons and their dependents who cannot qualify for the SSA's MEDICARE Part A and these persons can, and do, continue to use the CHAMPUS Program. A beneficiary who is not eligible for MEDICARE, Part A, must obtain a notice of disallowance from the Social Security Administration and submit it with a new retired military ID card which does not preclude CHAMPUS eligibility after his 65th birthday. It would seem, therefore, that the costs incurred by this segment of patient category should be budgeted for under the costs of the CHAMPUS Program.

VII. THE CHAMPUS PHASEBACK REPORT

Throughout the history of the CHAMPUS Program there has been a requirement for timely reports on the operations of the program. During the period 1968 to 1971 OCHAMPUS published an Annual Report. These reports, issued on 1 June of each year, reported disbursements based on all claims processed through 30 April of the year the report was issued. The Annual Reports issued on 1 June 1969 and 1970 reported disbursements, in six month segments, for the periods of 1 July 1967 to 31 December 1968 and 1 July 1968 to 31 December 1969, respectively. The Annual Reports issued in 1971 and 1972 had a slightly different reporting format. These reports covered only the preceding calendar year. To explain further, the report issued 1 June 1972 covered the accumulated disbursements for the period from 1 January 1971 to 31 December 1971. In addition, all of the above reports contained several statistical tables which reported such information as OCHAMPUS overhead operational costs, estimated numbers of eligible dependents, average daily patient loads, average length of stay, and average cost per day.

In 1972 OCHAMPUS discontinued the publication of these Annual Reports and began publishing a monthly report titled "Office for the Civilian Health and Medical Program of the Uniformed Services -- Phaseback Data." In a short time the report became known as the CHAMPUS Phaseback Report. The

Phaseback Report presents CHAMPUS data in three parts and nine categories.

The data is reported as an accumulated total for the "Merged FYS," as yearly totals for two fiscal years, and as monthly and yearly totals for two more fiscal years. To explain further, the September 1974 Phaseback Report would report on claims and costs for Merged Fiscal Years 1957 through 1971, for yearly totals for Fiscal Years 1972 and 1973, and for monthly figures and yearly totals for Fiscal Years 1974 and 1975. The Fiscal Year 1975 totals would, for the September 1974 report, include only the summed monthly figures for July, August and September 1974. The October 1974 Phaseback Report would be essentially the same except that the monthly figures for October would be included in the total reported for Fiscal Year 1975. In September 1975, the Merged Fiscal Years would be defined as the Fiscal Years 1957 to 1972. The yearly totals would be reported for Fiscal Years 1973 and 1974. Monthly figures and yearly totals for Fiscal Year 1975 and 1976 would also be reported.

The Phaseback Report covers actual payments made by OCHAMPUS to hospital contractors and fiscal administrators and other authorized payees, that is, payments made directly to beneficiaries. The report does not, however, reflect payments made by the contractors for which they have not been reimbursed by OCHAMPUS. Neither does it reflect the actual amount of care furnished beneficiaries for which civilian

sources of care have not yet submitted a claim for payment. Because of these reasons, and because of the normal accumulation of claims transactions during the month, the amounts shown for any time period on the report will, almost without exception, be different for amounts reflected for the same time period on past or future reports.

The amounts shown for each time period of the report reflect the care provided by civilian sources which has been paid on claims submitted within billing dates occurring during the indicated time period. The amounts shown are net amounts in that deductibles for outpatient care and drugs and for the handicapped program are computed and subtracted by the contractors. To the extent that all or part of this care was actually rendered in a prior period and, dependent upon any subsequent adjustment, amounts shown can vary from actual care rendered during that period. The name of this report is derived from the fact that, to the fullest degree possible, numbers and amounts of claims are "Phased Back" for inclusion in the accumulation for the time period in which the applicable care was rendered rather than the period in which the claims were paid.

Part 1 of the Phaseback Report reports the numbers of claims and the associated professional charges in summary form and in more detailed breakdowns of the data by user categories. The Summary Section reports the number of claims and associated costs in totals for all the branches of the

user services and in totals for each of the service branches, that is, for the Army, the Navy, the Air Force, and the Public Health Service. The next section titled "All Services" is essentially a breakdown, by patient categories and by cost categories, of the Summary Costs for all of the user services. The next four sections report in further detail the "All Services" data by the same patient and cost categories for each of the user services. These sections, as well as the section for All Services, each take up eighteen pages.

There are essentially four patient categories and five cost categories used in reporting the data in the above-mentioned sections. The patient categories are:

1. Dependents of active duty and NATO personnel.

2. Dependents of retired or deceased members, including Title III retirees.

3. Retired members.

4. The fourth patient category is actually a summarization of the above three categories and is termed "All Beneficiaries." In the following paragraphs each of the major cost categories and their subcategories will be identified and, where possible, an explanation of the composition of the elements of the category will be presented.

A. INPATIENT

This cost category covers the inpatient hospital and physician's charges. It must be pointed out that not all such

charges and claims are for actual inpatient care. Provisions of the CHAMPUS Program specify that all claims and charges for pregnancy cases shall be reported as inpatient charges. In addition, any outpatient care obtained thirty days prior to and 120 days after hospitalization is to be considered as inpatient charges for billing purposes.

The subcategories of the inpatient cost category are titled in the following general format: (patient category), Physician and Hospital Inpatient Only, Excluding Dental. An additional phrase of "Excluding Handicapped Dependents" is inserted in the subcategory title just after the patient category. Each subcategory is further broken down into three sections. The Hospital section reports the total number of inpatient days by the fiscal year and month breakdown discussed previously, the number of claims, and the cost for inpatient hospital care. The Physician section reports the number of claims and costs for inpatient physician care and the third section reports the total inpatient costs and the number of claims.

B. OUTPATIENT

This category reports outpatient care received by eligible beneficiaries. The phrase "Excluding Drugs, Handicapped, and Dental" appears in the subcategory title. Each subcategory is further reported by each of the patient categories. The comments in the previous section concerning the problem of

counting outpatient care as inpatient care should be recalled.

The subcategories in the outpatient data are:

1. Physician Outpatient Care
2. Psychotherapy Outpatient Care
3. Physician Outpatient Care Excluding Psychotherapy - and the other exclusions cited above.

In each of the subcategories the reporting format is to list the number of visits, the number of claims resulting from those visits, and the associated charges arising from the claims. In addition, the results of calculations for the average cost per visit and the average cost per claim are presented.

C. DRUGS

This cost category reports the claims and costs for prescription drugs purchased by the beneficiaries as part of their outpatient treatment. It also includes items of durable equipment which are determined by a physician as necessary for the effective treatment of a medical condition and which cost more than $50. Costs are reported for each patient category as in previous cost categories. The general report format for drugs is to list the number of prescriptions, the number of claims, and the government cost.

The government cost figure can be rather complex. If the drug is dispensed by a physician in connection with an office

visit or a home visit, the physician is reimbursed at the actual cost of the drug. If the drug is obtained through a pharmacy, the pharmacist is reimbursed for the cost of the drug at wholesale price plus a pharmacy professional fee which represents the average per prescription gross margin. Gross margin in this context consists of total prescription overhead costs plus net profit computed at a flat average charge. The professional fee is added to the acquisition cost of a drug to determine the maximum allowable prescription charge.

D. HANDICAPPED DEPENDENTS

The Program for the Handicapped applies only to dependents of active duty personnel who have a serious physical disability or moderate or severe mental retardation. The Physically Handicapped Only Excluding Dental subcategory reports the number of claims and associated charges for non-residential treatment and for residential treatment. In addition, the number of days of residential treatment are reported. A final section of this subcategory entitled "Total" is a summarization of the figures for the two classes of treatment.

The Mentally Retarded Only subcategory reports the number of claims and the professional costs for the treatment of the mentally retarded. The reporting format is the same as is used in the Physically Handicapped subcategory. The third subcategory is a summarization of the two preceding subcategories and utilizes the same general report format.

E. DENTAL CARE

Dental care is reported in terms of inpatient and outpatient costs and numbers of claims. As in previous cost categories there is a third subcategory of total claims and costs which summarizes the other two subcategories. The claims and costs for dental care are reported for each of the patient categories as was found in other cost categories.

F. AVERAGE DAILY PATIENT LOAD

Section seven of the Phaseback Data comprises Part 2 of the report. This part/section reports workload data in terms of average daily patient load for all services and for each of the user services. The average daily patient load is further broken down by the beneficiary categories. The general reporting format is:

Daily Average	12 Month Moving Average	Average Length of Stay
XXX	XXXX	X.X

It must be noted, however, that the 12 Month Moving Average is reported only for the monthly figures.

G. COSTS

Sections eight and nine comprise Part 3 of the Phaseback Data. Part 3 is concerned with costs of the operations of the program. Section eight reports the Inpatient Cost Per Patient Day. This data is reported by all services and by the user services by each of the patient categories discussed earlier. The general report format is shown below.

FISCAL YEAR(S)	
HOSPITAL DAYS	XXXX
TOTAL COST:	
HOSPITAL	$XXXX.XX
PHYSICIAN	$XXXX.XX
COST PER DAY:	
HOSPITAL	$XXX.XX
PHYSICIAN	$XXX.XX

The last section of the Phaseback Data is the Reconciliation of Report Data to Cost by Fiscal Year. Data in this section is reported in two methods. The first section reports on the Reconciliation of Report Data to Disbursements by All Services, by the user services, and by the Veterans Administration. The discussion in an earlier chapter concerning the VA's use of the CHAMPUS Program should be recalled. The report format used in this subsection is shown below:

	TOTAL	A	N	AF	PHS	VA
PHASEBACK DATA	XXXX	XX	XX	XX	XX	-0-
VA PROFESSIONAL COSTS	X					X
LESS VOUCHERS IN PROCESS	(XX)	(X)	(X)	(X)	(X)	(X)
ADD: WIRE ADVANCES IN PROCESS	XXX	XX	XX	XX	XX	X
ADJUSTMENTS TO HOSPITAL RATES	XXX	XX	XX	XX	XX	-0-
CONTRACTOR ADMIN COSTS	XX	X	X	X	X	X
CONUS (To 12/31/66)	XX	X	X	X	X	-0-
DENTAL	-0-	-0-	-0-	-0-	-0-	-0-
TBU (Claims Paid By OCHAMPUS)	XX	X	X	X	X	-0-
OTHER GOV'T AGENCIES	XX	X	X	X	X	-0-
OCHAMPUS OFFICE COSTS	XX	X	X	X	X	-0-
TOTAL DISBURSEMENTS	XXXXX	XX	XX	XX	XX	X

The remaining subsection titled "Total Cost by Fiscal Year" reports the total costs of the program, accumulated

total costs for the merged fiscal years, the yearly totals for four more fiscal years, and a grand total of all the costs incurred over the life of the CHAMPUS Program.

VIII. READING THE CHAMPUS PHASEBACK DATA

The preceding chapter discussed the format of the CHAMPUS Phaseback Data in order that one might get an idea of the composition of this voluminous report. Because of its format, the Phaseback Data is relatively easy to read. It is not, however, easy to relate what one has read to any previous reports.

A. CALENDAR YEARS 1968 TO 1971

The published Annual Reports of the Office for CHAMPUS for Calendar Years 1968 and 1971 were used in compiling the data for Tables V, VI, VII and VIII. In Calendar Years 1968 and 1969 the CHAMPUS report format was to present accumulated costs on a six month basis in four basic cost categories and to include three six month periods in each report [Refs. 69 and 70]. The Annual Reports for Calendar Years 1970 and 1971 had a different format. Costs were accumulated for a full calendar year and reported on a yearly basis, that is, they were reported without the six month breakdowns found in the previous reports. Lacking detailed knowledge of the accounting procedures used, the reported figures were divided by two and equal amounts were assigned to each fiscal year. Thus, the dollar amounts reported for Fiscal Years 1970 and 1971 should be regarded as approximations only. They are used later in this chapter to demonstrate the program's growth and, as such, the figures shown tend to be quite accurate.

TABLE V

REPORTED CHAMPUS COSTS FOR FISCAL YEAR 1968
($ IN THOUSANDS)

COST CATEGORY[1]	ARMY	NAVY	AIR FORCE	TOTAL
Inpatient	$15,809	$15,771	$10,398	$ 90,853
Hospital	18,700	17,771	12,404	
Inpatient	948	1,342	967	9,951
Physician	2,037	2,573	2,084	
Outpatient	8,176	8,779	5,442	48,809
(Note 2)	9,550	10,263	6,599	
Handicapped	356	267	436	2,955
Program	537	542	817	
TOTAL	$56,113	$57,308	$39,149	$152,568

Source: CHAMPUS, TWELFTH ANNUAL REPORT, 1969.

Note 1: First number in each cost category represents costs for first six months of the fiscal year. Second number is the second six months of the fiscal year.

Note 2: Includes drugs and outpatient dental costs.

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TABLE VI

REPORTED CHAMPUS COSTS FOR FISCAL YEAR 1969
($ IN THOUSANDS)

COST CATEGORY[1]	ARMY	NAVY	AIR FORCE	TOTAL
Inpatient	$23,525	$20,427	$14,744	$122,893
Hospital	24,979	22,486	16,732	
Inpatient	11,981	11,777	7,678	64,746
Physician	12,513	12,451	8,346	
Outpatient	1,670	2,039	1,695	15,703
(Note 2)	3,127	3,888	3,284	
Handicapped	782	697	1,184	6,375
Program	1,006	970	1,734	
TOTAL	$79,583	$74,735	$55,397	$209,715

Source: CHAMPUS, THIRTEENTH ANNUAL REPORT, 1970.

Note 1: First number in each cost category represents costs for first six months of the fiscal year. Second number is the second six months of the fiscal year.

Note 2: Includes drugs and outpatient dental costs.

TABLE VII

REPORTED CHAMPUS COSTS FOR FISCAL YEAR 1970
($ IN THOUSANDS)

COST CATEGORY[1]	ARMY	NAVY	AIR FORCE	TOTAL
Inpatient	$26,907	$23,169	$17,040	$146,879
Hospital	31,590	26,834	21,339	
Inpatient	12,625	12,329	7,894	70,868
Physician	14,456	13,701	9,863	
Outpatient	2,053	2,632	2,172	18,440
(Note 2)	3,418	4,310	3,855	
Handicapped	1,020	1,061	1,771	9,497
Program	1,385	1,581	2,679	
TOTAL	$93,454	$85,617	$66,613	$245,684

Source: CHAMPUS, FOURTEENTH ANNUAL REPORT, 1971.

Note 1: First number in each cost category represents costs for first six months of the fiscal year. Second number is the second six months of the fiscal year.

Note 2: Includes drugs and outpatient dental costs.

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TABLE VIII

REPORTED CHAMPUS COSTS FOR FISCAL YEAR 1971
($ IN THOUSANDS)

COST CATEGORY[1]	ARMY	NAVY	AIR FORCE	TOTAL
Inpatient	$31,590	$26,834	$21,339	$174,846
Hospital	35,685	31,356	28,042	
Inpatient	14,456	13,701	9,863	82,316
Physician	16,015	15,581	12,700	
Outpatient	3,418	4,310	3,855	28,229
(Note 2)	4,782	6,214	5,650	
Handicapped	1,385	1,581	2,679	15,208
Program	2,170	2,704	4,689	
TOTAL	$109,501	$102,281	$ 88,817	$300,599

Source: CHAMPUS, FIFTEENTH ANNUAL REPORT, 1972.

Note 1: First number in each cost category represents costs for first six months of the fiscal year. Second number is the second six months of the fiscal year.

Note 2: Includes cost of drugs and inpatient and outpatient dental costs.

Exhibit 33 demonstrates still another problem found in reading the CHAMPUS reports. The two sets of figures represent the first half of Fiscal Year 1969 as reported at the end of Calendar Years 1968 and 1969 respectively. In both cases, the reported dollar figures represent all claims processed through April 30 of the next calendar year. If one can assume that these differences are typical in the Annual Reports, the results of any comparisons made with the amounts shown in Tables VI to IX must be viewed with some degree of skepticism.

B. FISCAL YEARS 1973 AND 1974

Tables IX and X are the reported figures for Fiscal Years 1972 and 1973. The dollar amounts for these years were obtained from the July 1974 Phaseback Data [Ref. 73]. The Office for CHAMPUS began using this report format in 1972. To date, however, copies of the reports published in 1972 and 1973 have not been obtainable.

In a Phaseback Data which is issued on a monthly basis, the costs are accumulated on a monthly basis. The particular month's report used exerts an influence on the reported costs. For example, in Table X the reported Inpatient Hospital claims costs for the Navy is $70,734,000 in the July report. The same cost category in the August 1974 report is $70,739,000 and in the September 1974 report it is $70,751,000. One could argue for using the latest report that is available. To do so, however, would produce a wider difference in the totals

EXHIBIT 33

COST CATEGORY	END OF CALENDAR YEAR 1968				END OF CALENDAR YEAR 1969			
	($ IN THOUSANDS)							
	ARMY	NAVY	AIR FORCE	TOTAL	ARMY	NAVY	AIR FORCE	TOTAL
Inpatient Hospital	$21,274	$18,669	$13,420	$53,363	$23,525	$20,427	$14,744	$58,696
Inpatient Physician	1,362	1,696	1,412	4,469	11,981	11,777	7,678	31,436
Outpatient Claims	10,634	10,755	6,915	28,304	1,670	2,039	1,695	5,404
Handicapped Program	514	461	738	1,713	782	697	1,184	2,663
TOTAL	$33,784	$31,581	$22,485	$87,850	$37,958	$34,940	$25,301	$98.199

Source: Figures for Calendar Year 1968 from CHAMPUS, TWELFTH ANNUAL REPORT, 1970. Figures for Calendar Year 1969 from CHAMPUS, THIRTEENTH ANNUAL REPORT, 1971. The wide variance for figures for cost categories Inpatient Physician and Outpatient Claims when compared to totals for each service would seem to indicate a change in the definition of the costs that compose each of the cost categories.

TABLE IX

REPORTED CHAMPUS COSTS FOR FISCAL YEAR 1972
($ IN THOUSANDS)

COST CATEGORY[1]	ARMY	NAVY	AIR FORCE	TOTAL
Inpatient Hospital	$74,687	$70,734	$ 66,336	$211,757
Inpatient Physician	32,621	34,165	29,705	96,491
Outpatient (Note 2)	11,684	15,075	18,199	44,958
Handicapped Program	2,663	3,118	4,080	9,855
TOTAL	$121,655	$123,086	$118,320	$363,061

Source: CHAMPUS PHASEBACK REPORT, July 1974.

Note 1: Number in each cost category represents an entire fiscal year. No six month breakdowns available.
Note 2: Includes drugs and inpatient and outpatient dental care.

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TABLE X

REPORTED CHAMPUS COSTS FOR FISCAL YEAR 1973
($ IN THOUSANDS)

COST CATEGORY[1]	ARMY	NAVY	AIR FORCE	TOTAL
Inpatient Hospital	$76,134	$ 79,475	$ 78,402	$234,011
Inpatient Physician	31,091	36,401	34,703	102,195
Outpatient (Note 2)	13,960	19,199	22,652	55,811
Handicapped Program	2,648	2,655	4,386	9,689
TOTAL	$123,833	$137,730	$140,143	$401,706

Source: Same as Table 7.
Note 1: Same as Table 7.
Note 2: Same as Table 7.

-- and even then the reported figures would not be a "total" cost for that year. Another alternative would be to use only cost figures that are at least two years old. While such a procedure may produce more valid comparisons of cost, it would also exclude those years in which the cost increases have been the most dramatic.

C. EXPENDITURE RATES

Based on historical operating data over the eighteen year life of the program, CHAMPUS officials have been able to plot the rate at which funds are disbursed to contractors. The appropriation for the CHAMPUS Program is what is termed a "one-year" appropriation. This means that obligations may be incurred against the appropriation for one fiscal year. The expensing of these obligations may, however, take place over the following two fiscal years. To rephrase this last statement, the CHAMPUS Program payments cover 36 months. To explain further, care may be provided in July of Fiscal Year 197X but claims will continue to be paid until the thirtieth of June, Fiscal Year 197X+2.

In terms of financial management, the rate of expenditure of funds in any program is important. By the very nature of the CHAMPUS Program the rate of obligation is uncontrollable since a potential obligations occur anytime a dependent or a retired person receives care from a civilian source. The rate of expenditures for the CHAMPUS Program have been, and are, carefully monitored [Ref. 74]. Exhibit 34 depicts, in terms

EXHIBIT 34

CHAMPUS PROGRAM EXPENDITURE RATES
EXPRESSED AS PERCENTAGES

MONTH	FY 70	FY 71	FY 72	FY 73
1	.2	.05	.05	.05
2	1.0	.2	.6	.6
3	4.3	2.3	5.3	5.6
4	9.6	5.9	9.7	11.6
5	16.2	11.9	17.7	17.6
6	22.4	19.5	23.2	24.1
7	27.0	26.3	31.6	30.2
8	34.7	33.8	37.8	38.5
9	43.8	44.6	46.6	45.6
10	52.3	53.5	53.0	56.4
11	60.5	60.1	64.2	63.8
12	68.5	71.5	74.7	73.3
13	77.3	81.4	80.1	79.8
14	82.6	87.7	87.9	87.5
15	87.3	92.5	93.3	92.1
16	90.9	94.4	95.6	94.6
17	93.6	95.8	96.6	95.7
18	95.3	96.8	97.1	96.6
19	96.3	97.5	97.7	97.4
20	97.0	97.8	98.1	97.7
21	97.7	98.2	98.5	98.2
22	98.1	98.5	98.7	98.5
23	98.6	98.7	99.1	98.7
24	98.8	99.0	99.2	99.0
25	99.0	99.2	99.3	99.2
26	99.2	99.3	99.3	99.3

of percentage of total funds available at the end of the fiscal year, the rate of expenditure of funds over the life of each fiscal year's appropriation. The exhibit spans four of the more recent fiscal year. It will be noted that the exhibit covers only twenty-six months for each fiscal year's appropriation. The increment in percentage of funds expended for the remaining ten months totals less than one percent for all years. As can be seen in all four of the years studied, by the twenty-fourth month, over 99 percent of available funds have been expended. It should also be noted that the expenditure rate for any given month, especially after the twelfth month, remains relatively constant over the four years shown.

The data for Fiscal Year 1974, as reported in the July 1974 Phaseback Data, represents the amount of expenditures through the twelfth month of the porgram. From Exhibit 33 one can see that by the twelfth month an average of about 72 percent of the total expenditures have been recorded. Using the July 1974 data and projecting it through the twenty-sixth month results in the figures in Table XII. By using the projection technique just described the figures in this table may be considered compatible with the figures shown for the other time periods discussed above. The total costs expended for the program and by each of the three branches of the Armed Forces are presented graphically in Exhibits 35 and 36. As can be seen from the program totals graph, the cost for the

TABLE XI

PROJECTED CHAMPUS COSTS FOR FISCAL YEAR 1974
($ IN THOUSANDS

COST CATEGORY[1]	ARMY	NAVY	AIR FORCE	TOTAL
Inpatient Hospital	$91,352	$99,806	$100,137	$291,295
Inpatient Physician	36,023	42,662	43,231	121,916
Outpatient (Note 1)	12,041	16,923	18,211	47,145
Handicapped Program	2,728	3,670	4,981	11,379
TOTAL	$142,144	$163,061	$166,560	$471,765

Source: Same as Table X.

Note 1: Includes drugs and inpatient and outpatient dental costs.

CHAMPUS Program are continuing to rise at a fairly rapid rate. Perhaps the most significant feature of the Armed Services graph is relatively rapid growth exhibited by the Air Force. In 1968 it accounted for about 25.3 percent of the total program costs. In the projections for Fiscal Year 1974 it accounts for 35.3 percent of the total costs.

EXHIBIT 35

TOTAL CHAMPUS PROGRAM EXPENDITURES
FY 1968 TO FY 1974

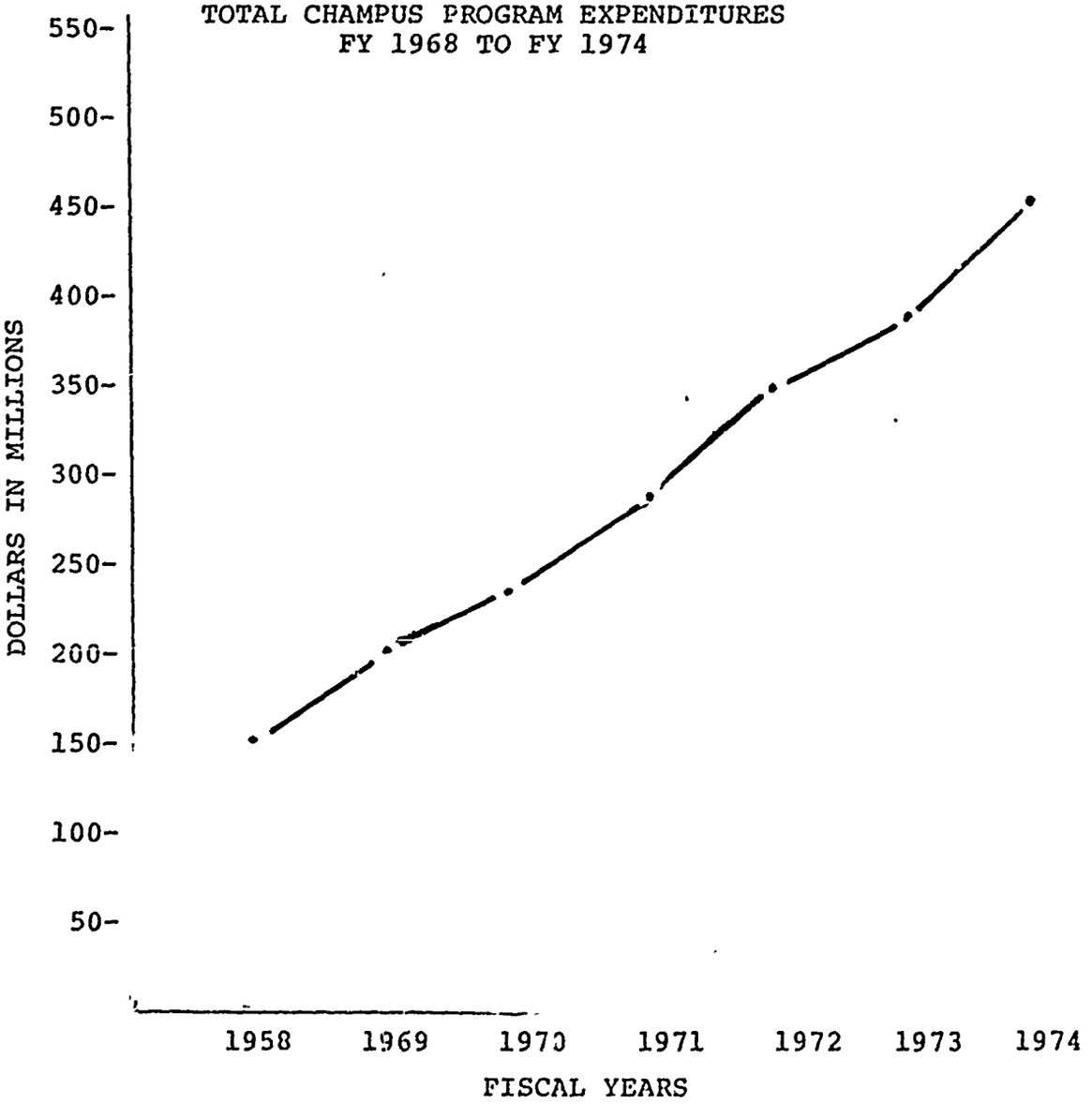
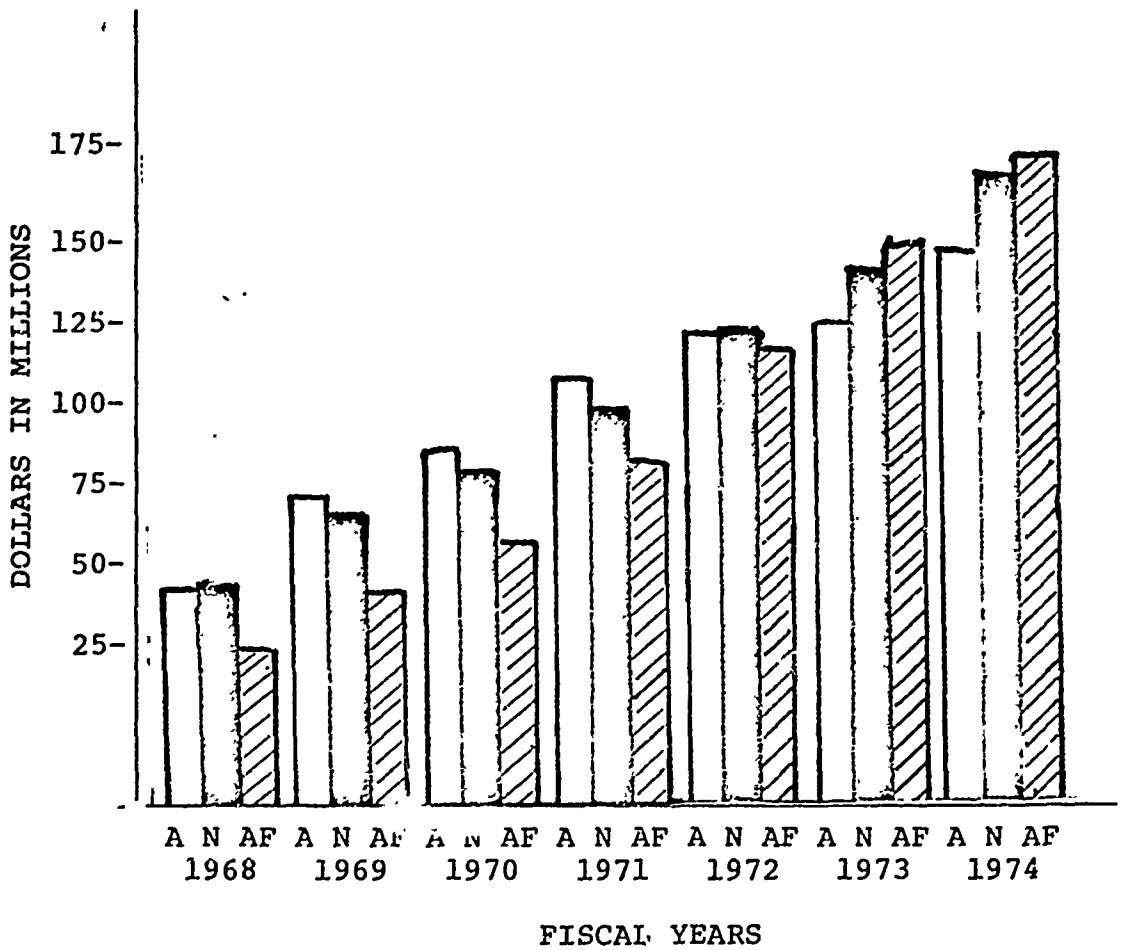


EXHIBIT 36

CHAMPUS PROGRAM EXPENDITURES
BY BRANCH OF SERVICE
FY 1968 TO FY 1974



D. INTERPRETING THE CHAMPUS REPORT

Reading a CHAMPUS Phaseback Report for any given month is not too difficult. It is more difficult, however, to interpret the information found in the report without resorting to previous reports. The following tables represent an attempt to attach some significance to the Phaseback Data.

The tables were constructed from data found in the September 1974 Phaseback Data.

Table XII was developed by using the data found in the Summary Section of the report. Costs for each entry were divided by the number of claims. The result, the average expenditure per claim, is shown. The comments made earlier concerning the problems associated with counting some outpatient care as inpatient care should be kept in mind when reading this and successive tables.

Tables XII through XIX are based on the information from Section 2, All Services, and Section 4, Navy, of the Phaseback Data. The calculations used to compile Table XIII and Table XIV are as follows.

1. $\frac{\text{Hospital Days}}{\text{Hospital Claims}}$ = Average Days Per Claim

2. $\frac{\text{Hospital Costs}}{\text{Hospital Claims}}$ = Average Cost Per Claim - Hospital

3. $\frac{\text{Hospital Costs}}{\text{Hospital Days}}$ = Average Cost Per Hospital Day

4. $\frac{\text{Physician Costs}}{\text{Physician Claims}}$ = Average Cost Per Hospital Day

5. $\frac{\text{Total Costs}}{\text{Total Claims}}$ = Average Cost Per Inpatient Claim

Tablex XV, XVI, and XVII concerning outpatient charges were constructed by entering the average cost per claim and average cost per visit from the Phaseback Data and performing the following calculations.

1. $\frac{\text{Number of Visits}}{\text{Number of Claims}}$ = Average Visits Per Claim - Outpatient

TABLE XII

DISTRIBUTION OF ALL CHAMPUS PROFESSIONAL COSTS
BY ALL BRANCHES

Average Expenditure Per Claim

	All Branches	Army	Navy-MC	Air Force	PHS
Merged FY's	$128.00	$134.20	$127.80	$122.90	$129.80
FY 72	165.30	173.70	159.90	162.80	172.10
FY 73	162.70	170.10	159.00	159.80	169.10
FY 74:					
July '73	195.75	207.17	193.11	186.38	191.54
August	190.61	199.01	190.61	182.70	213.94
September	182.41	192.37	181.60	174.87	190.10
October	173.14	181.69	171.21	168.20	174.74
November	170.30	180.50	167.34	164.95	173.03
December	175.47	185.91	174.26	169.00	165.66
January '74	160.15	170.82	155.92	156.03	159.85
February	163.97	174.11	162.86	157.12	164.64
March	166.04	177.52	159.83	163.18	165.78
April	163.31	174.05	160.19	160.14	165.27
May	162.40	171.47	156.50	160.44	172.78
June	146.95	153.34	144.86	143.39	157.55
Total FY 74	169.80	179.50	167.00	164.80	173.62

TABLE XIII

RETIRED/DECEASED DEPENDENTS
PHYSICIAN AND HOSPITAL INPATIENT COSTS
(EXCLUDING DENTAL)

	HOSPITAL						PHYSICIAN		TOTAL	
	Average Days Per Claim		Average Cost Per Claim		Average Cost Per Day		Average Cost Per Claim		Average Cost Per Inpatient Claim	
	All	Navy	All	Navy	All	Navy	All	Navy	All	Navy
MERGED FYS	9.84	9.59	$359.50	$363.90	$36.50	$37.92	$ 98.84	$101.32	$197.50	$197.62
FY 72	10.21	9.87	436.76	450.67	42.73	45.64	108.80	111.53	231.10	234.34
FY 73	10.09	9.88	456.57	470.31	45.22	47.56	110.83	114.50	240.41	244.69
FY 74										
July '73	9.54	9.35	446.28	471.60	46.97	50.94	109.55	109.36	237.26	245.83
August	9.37	9.04	450.54	471.17	48.07	52.11	113.49	116.58	241.29	247.87
September	9.02	8.94	458.63	485.30	50.81	54.25	112.80	118.81	244.12	162.84
October	9.46	9.51	473.96	497.27	50.07	52.25	116.12	118.66	246.78	253.03
November	8.77	8.52	467.42	476.53	53.25	55.89	115.14	118.37	245.27	281.16
December	10.43	10.04	512.34	544.42	49.08	54.19	120.12	122.73	271.41	281.16
January '74	8.84	8.71	469.54	491.60	53.09	56.42	113.78	116.43	242.65	249.61
February	8.91	8.91	495.34	531.54	55.55	59.59	118.02	122.42	257.26	269.24
March	9.14	8.77	505.16	516.79	55.32	58.91	119.27	123.67	265.47	268.30
April	9.05	8.78	515.09	529.33	56.91	60.24	121.93	123.00	266.14	269.88
May	8.61	8.52	531.87	553.63	61.71	64.93	124.46	131.02	279.44	287.93
June	8.82	8.56	547.25	579.01	62.00	67.57	129.14	133.52	282.88	297.93
Total FY 74	9.17	8.98	487.26	509.74	53.09	56.70	117.43	120.74	255.50	262.97

TABLE XIV

RETIRED MEMBERS
PHYSICIAN AND HOSPITAL INPATIENT COSTS
(EXCLUDING DENTAL)

	HOSPITAL						PHYSICIAN		TOTAL	
	Average Days Per Claim		Average Cost Per Claim		Average Cost Per Day		Average Cost Per Claim		Average Cost Per Inpatient Claim	
	All	Navy	All	Navy	All	Navy	All	Navy	All	Navy
MERGED FYS	9.35	9.33	$394.77	$400.06	$42.19	$42.85	$104.17	$107.46	$214.02	$217.07
FY 72	8.77	8.97	479.65	489.72	54.66	54.55	115.91	118.37	249.61	251.91
FY 73	8.28	8.34	484.65	506.-7	58.52	60.69	114.34	117.34	250.40	256.10
FY 74										
July '73	8.01	8.49	472.54	515.99	58.93	60.74	112.45	111.03	248.04	256.85
August	8.15	8.76	482.16	537.51	59.15	61.34	117.00	121.31	251.27	269.20
September	8.24	8.41	499.92	535.04	60.65	63.32	118.40	128.76	261.04	274.45
October	7.86	7.80	481.54	503.39	61.19	64.52	120.81	124.15	251.12	257.32
November	8.16	8.11	523.88	542.30	64.14	66.79	124.85	127.97	269.72	274.66
December	7.82	7.95	516.74	559.12	66.00	70.26	120.64	134.81	269.65	290.24
January '74	7.76	7.78	505.75	535.14	65.10	68.61	121.74	121.26	258.46	260.09
February	8.15	8.40	549.75	618.76	67.43	73.61	128.82	130.08	282.68	301.54
March	7.95	8.41	548.50	618.28	68.91	73.44	113.07	132.02	283.30	301.07
April	6.67	8.54	555.11	595.22	67.29	69.66	128.89	134.16	284.44	294.99
May	8.13	8.05	616.75	621.01	75.83	77.11	131.73	134.99	310.90	307.44
June	7.94	8.21	598.75	646.80	75.38	78.73	130.98	133.17	303.40	312.32
Total FY 74	8.03	8.24	526.06	565.00	65.43	68.50	123.25	127.41	271.38	281.79

TABLE XV

PHYSICIAN OUTPATIENT CARE
(EXCLUDING DRUGS, HANDICAPPED, PSYCHOTHERAPY, AND DENTAL)

	RET/DEC DEPENDENTS						RETIRED MEMBERS					
	Average Visits Per Claim		Average Cost Per Claim		Average Cost Per Visit		Average Visits Per Claim		Average Cost Per Claim		Average Cost Per Visit	
	All	Navy	All	Navy	All	Navy	All	Navy	All	Navy	All	Navy
MERGED FYS	3.76	3.53	$38.47	$38.66	$10.21	$10.94	3.60	3.32	$40.29	$39.76	$11.16	$11.96
FY 72	3.25	3.96	39.32	38.84	12.08	12.67	2.97	2.75	40.50	38.52	13.60	15.00
FY 73	2.86	2.66	40.02	39.76	14.05	14.90	2.55	2.33	39.61	36.94	15.52	15.82
FY 74												
July '73	1.97	1.85	39.13	40.42	19.89	21.75	1.47	1.27	39.2o	37.92	26.61	29.71
August	2.15	2.04	40.69	41.21	18.87	20.19	1.77	1.72	39.04	38.00	21.94	22.07
September	2.01	1.94	36.35	35.61	18.07	18.34	1.86	1.72	39.14	36.99	20.97	21.49
October	2.14	1.97	35.44	35.35	16.52	17.94	2.01	1.81	40.15	38.20	19.97	21.00
November	2.22	2.07	37.04	36.16	16.67	17.41	2.08	1.90	39.54	36.77	18.93	19.25
December	2.63	2.43	37.74	36.80	14.31	15.10	2.51	2.22	41.12	38.92	16.35	17.46
January '74	2.15	1.98	35.52	43.67	16.50	17.50	1.97	1.83	37.77	36.32	19.08	19.77
February	2.12	2.01	35.64	35.10	16.75	17.46	1.88	1.79	39.39	38.55	20.90	21.51
March	2.18	2.05	36.38	35.81	16.62	17.45	2.01	1.80	39.66	38.32	19.68	21.25
April	2.22	2.09	37.07	36.23	16.70	17.28	2.02	1.88	39.95	38.36	19.74	20.38
May	2.36	2.22	38.14	37.18	16.16	16.74	2.11	1.97	40.49	39.27	19.11	19.87
June	3.13	2.89	41.38	40.27	13.22	13.90	2.81	2.64	42.93	41.25	15.25	15.58
Total FY 74	2.31	2.16	37.47	36.83	16.16	17.03	2.09	1.92	39.99	38.34	19.05	19.88

TABLE XVI

PSYCHOTHERAPY OUTPATIENT CARE

	RET/DEC DEPENDENTS						RETIRED MEMBERS					
	Average Visits Per Claim		Average Cost Per Claim		Average Cost Per Visit		Average Visits Per Claim		Average Cost Per Claim		Average Cost Per Visit	
	All	Navy	All	Navy	All	Navy	All	Navy	All	Navy	All	Navy
MERGED FYS	5.81	5.66	$119.65	$119.90	$20.56	$21.17	6.25	6.01	$127.16	$122.15	$20.33	$20.31
FY 72	5.14	4.96	124.57	124.79	24.22	25.13	5.58	5.48	126.44	124.67	22.62	22.75
FY 73	4.69	4.27	115.43	115.00	24.57	26.89	4.78	4.40	120.11	118.91	25.11	26.96
FY 74												
July '73	4.67	4.82	85.35	86.71	18.24	17.99	5.06	5.94	95.72	98.45	18.88	18.08
August	4.82	4.83	99.59	97.51	20.65	20.17	4.92	4.65	103.31	95.54	19.78	20.53
September	5.26	5.25	109.96	109.25	20.87	20.92	5.50	5.67	115.20	114.52	20.92	20.17
October	5.25	5.30	114.74	114.79	21.82	21.66	5.61	5.77	124.23	129.83	22.12	22.50
November	5.35	5.47	118.34	118.76	22.11	21.69	5.88	6.25	132.41	140.72	22.50	22.52
December	6.05	5.20	132.05	136.82	21.80	22.07	6.11	5.96	135.20	132.16	22.09	22.15
January '74	5.09	5.02	117.49	119.03	23.05	23.68	5.56	5.61	128.20	126.20	23.03	22.47
February	5.07	5.21	116.80	121.62	23.00	23.34	5.22	5.25	125.48	125.75	24.00	23.93
March	5.34	5.44	124.12	126.45	23.25	23.22	5.47	5.40	129.07	128.88	23.57	23.86
April	5.11	5.03	118.67	117.02	23.20	23.24	5.19	4.98	122.85	116.48	23.63	23.35
May	5.15	4.99	122.52	119.07	23.76	23.82	5.53	5.72	133.83	139.34	24.18	24.36
June	5.27	5.38	129.14	135.22	24.50	25.15	5.37	5.41	132.36	135.91	24.62	25.08
Total FY 74	5.24	5.28	117.33	118.60	22.39	22.46	5.50	5.53	124.67	125.07	22.74	22.61

TABLE XVII

PHYSICIAN OUTPATIENT CARE
(EXCLUDING DRUGS, HANDICAPPED, AND DENIAL)

	RET/DEC DEPENDENTS						RETIRED MEMBERS					
	Average Visits Per Claim		Average Cost Per Claim		Average Cost Per Visit		Average Visits Per Claim		Average Cost Per Claim		Average Cost Per Visit	
	All	Navy	All	Navy	All	Navy	All	Navy	All	Navy	All	Navy
MERGED FYS	4.05	3.82	$49.94	$49.67	$12.31	$13.14	3.83	3.55	$47.66	$46.67	$12.43	$12.99
FY 72	3.56	3.38	53.42	53.33	14.97	15.44	3.20	2.99	48.03	46.25	14.98	15.75
FY 73	3.12	2.21	51.10	50.13	16.23	17.60	2.76	2.52	47.21	44.51	17.09	17.34
FY 74												
July '73	2.46	2.35	47.54	48.24	19.32	25.57	1.89	1.75	45.85	44.86	24.20	20.45
August	2.65	2.51	51.63	50.69	19.47	21.65	2.16	2.08	46.91	45.04	21.67	20.18
September	2.61	2.49	49.90	48.00	19.11	21.09	2.28	2.18	47.98	46.03	20.96	19.25
October	2.66	2.46	48.69	47.24	18.27	21.40	2.39	2.23	49.10	47.73	20.51	19.13
November	2.70	2.55	49.51	47.69	18.32	20.13	2.46	2.34	48.74	47.19	19.78	18.69
December	3.20	3.02	53.37	52.35	16.65	18.58	2.89	2.62	50.97	48.72	17.63	17.32
January '73	2.55	2.37	46.80	45.51	18.29	20.41	2.30	2.18	46.10	44.69	19.96	19.18
February	2.51	2.40	46.42	45.81	18.42	22.04	2.18	1.09	47.15	46.18	21.57	19.03
March	2.58	2.44	47.41	46.23	18.34	21.84	2.31	2.12	47.46	46.38	20.48	18.93
April	2.58	2.42	47.35	45.40	18.32	20.95	2.29	2.13	47.01	44.75	20.49	18.68
May	2.69	2.52	48.27	46.17	17.90	20.77	2.30	2.27	48.00	47.25	20.05	18.28
June	3.41	3.20	52.99	52.17	15.52	17.18	3.05	2.89	51.18	49.78	16.77	16.26
Total FY 74	2.74	2.58	49.11	47.81	17.89	20.52	2.42	2.27	48.17	46.67	19.86	18.52

TABLE XVIII

DRUG CLAIMS

	RET/DEC DEPENDENTS						RETIRED MEMBERS					
	Average Prescriptions Per Claim		Average Cost Per Claim		Average Cost Per Prescription		Average Prescriptions Per Claim		Average Cost Per Claim		Average Cost Per Prescription	
	All	Navy	All	Navy	All	Navy	All	Navy	All	Navy	All	Navy
MERGED FYS	4.93	5.03	$17.13	$17.48	$3.46	$3.47	4.93	5.03	$17.13	$17.48	$3.46	$3.47
FY 72	5.75	5.54	21.46	20.53	3.72	3.70	5.75	5.54	21.46	20.53	3.72	3.70
FY 73	5.78	5.48	22.45	21.39	3.88	3.90	5.78	5.48	22.45	21.39	3.88	3.90
FY 74												
July '73	3.35	3.64	12.48	12.90	3.72	3.53	3.35	3.64	12.47	12.88	3.72	3.53
August	3.44	3.74	13.76	14.71	3.99	3.92	3.44	3.74	13.76	14.70	3.99	3.92
September	4.00	4.14	16.10	16.58	4.01	4.00	4.00	4.14	16.11	16.58	4.01	4.00
October	4.24	4.54	17.12	18.00	4.03	3.96	4.24	4.53	17.13	17.99	4.03	3.96
November	4.61	4.54	18.69	18.56	4.05	4.08	4.61	4.54	18.69	18.56	4.05	4.08
December	5.93	5.65	24.04	23.19	4.05	4.10	5.93	5.65	24.04	23.20	4.05	4.10
January '74	4.74	4.51	18.98	18.43	5.53	4.08	4.74	4.51	18.97	18.40	3.99	4.08
February	4.71	4.58	18.81	18.32	3.99	3.99	4.71	4.58	18.81	18.32	3.99	3.99
March	4.92	4.80	19.73	19.74	4.00	4.11	4.92	4.80	19.73	19.74	4.00	4.11
April	5.03	4.82	19.94	19.30	3.95	4.00	5.04	4.82	19.99	19.30	3.96	4.00
May	5.54	5.25	22.82	21.60	4.11	4.10	5.54	5.25	22.82	21.60	4.11	4.10
June	8.24	7.58	24.00	30.85	4.08	4.06	8.24	7.58	23.98	30.85	4.08	4.06
Total FY 74	5.42	5.21	21.89	21.11	4.03	4.05	5.42	5.21	21.91	21.11	4.03	4.05

TABLE XIX

DENTAL CARE

	RET/DEC DEPENDENTS						RETIRED MEMBERS					
	Inpatient Average Cost Per Claim		Outpatient Average Cost Per Claim		Total Average Cost Per Claim		Inpatient Average Cost Per Claim		Outpatient Average Cost Per Claim		Total Average Cost Per Claim	
	All	Navy	All	Navy	All	Navy	All	Navy	All	Navy	All	Navy
MERGED FYS	$182.69	$181.64	$142.59	$143.98	$153.97	$155.19	$ 198.25	$ 215.11	$2007.15	$ 190.24	$200.04	$195.72
FY 72	198.65	177.12	155.23	154.03	185.54	168.62	358.20	121.50	121.50	135.91	203.30	125.44
FY 73	181.92	269.11	147.93	147.10	171.28	180.37	171.05	126.00	185.69	192.60	181.41	167.62
FY 74												
July '73	196.65	206.90	116.72	107.40	182.43	187.1?	155.50	86.00	109.20	66.00	122.42	70.20
August	184.14	182.12	150.67	139.06	176.80	171.92	0.00	0.00	274.58	532.50	274.58	532.50
September	171.85	176.31	111.03	115.14	156.13	159.74	111.50	0.00	231.00	86.33	211.08	86.33
October	188.98	209.04	162.90	179.67	181.57	198.14	242.18	352.33	87.21	105.75	155.40	211.57
November	204.48	211.57	142.73	134.53	181.36	184.13	418.66	434.75	211.16	236.12	261.08	302.33
December	219.47	201.82	142.43	141.16	189.29	177.87	117.90	80.00	195.45	174.00	169.60	139.81
Janaury '74	178.53	181.96	147.70	124.77	161.72	151.85	232.50	450.00	324.55	442.77	291.67	443.50
February	235.27	286.26	140.53	103.97	171.35	142.46	164.20	146.00	163.65	174.66	163.76	167.50
March	210.62	206.42	138.03	120.96	156.52	142.08	212.66	243.75	216.07	176.33	215.05	203.30
April	183.78	218.24	206.48	229.67	200.00	226.50	149.00	435.00	186.66	1814.00	179.13	266.00
May	169.73	179.55	154.37	132.48	159.05	139.25	82.50	18.00	203.85	226.75	192.81	203.66
June	218.92	256.72	147.44	159.63	162.38	189.10	1088.00	1088.00	282.54	390.00	455.14	651.75
Total FY 74	192.72	199.76	149.13	142.90	174.49	175.02	248.17	366.00	209.08	239.54	218.97	267.77

Table XVIII covers drug claims. The calculations used in compiling this table are:

1. $\frac{\text{Number of Prescriptions}}{\text{Number of Claims}} = \text{Average Prescriptions Per Claims}$

2. $\frac{\text{Government Cost}}{\text{Number of Claims}} = \text{Average Cost Per Claim}$

3. $\frac{\text{Government Cost}}{\text{Number of Prescriptions}} = \text{Average Cost Per Prescription}$

The calculations used in compiling Table XIX, Dental Care, are:

1. $\frac{\text{Inpatient Cost}}{\text{Inpatient Claims}} = \text{Average Inpatient Cost Per Claim - Dental}$

2. $\frac{\text{Outpatient Cost}}{\text{Outpatient Claims}} = \text{Average Outpatient Cost Per Claim - Dental}$

3. $\frac{\text{Total Cost}}{\text{Total Claims}} = \text{Average Total Cost Per Claim - Dental}$

From reading these tables one can get an idea of the affect of the usage of the CHAMPUS Program by Navy beneficiaries. The tables indicate that, for most of the cost categories, Navy beneficiaries incurred a slightly higher average cost for the treatment that they received as compared to the total costs for each category. It is possible that, since most Navy beneficiaries live in large coastal cities, the higher costs can be attributed to the higher costs of living in those cities.

It is especially interesting to note Table XVIII, Drug Claims. Note that the Average Cost Per Prescription, the Average Cost Per Claim, and the Average Number of Prescriptions are nearly identical in all entries for the dependents

of retired and deceased personnel and the entries for retired members. This would seem to indicate that the dependents and the retired members purchased exactly the same types of prescriptions in exactly the same amounts and at the same cost. The probability of such an occurrence is extremely small. A more likely conclusion is that the OCHAMPUS computer program for this cost category contains some anomaly that produces this phenomenon. This question was raised in conversations with the Director of Management Services at OCHAMPUS. No definitive answer to the question has been provided.

The above tables presented the results of calculations described above for dependents of retired and deceased persons and for retired members only. No attempt was made to perform similar calculations for dependents of active duty persons or for the handicapped program. The effect of the deductible provisions in the outpatient category and the variable - according to rate or rank - co-payments required in the Handicapped Program make the results of such calculations meaningless.

IX. SUMMARY OF FINDINGS

This study of the CHAMPUS Program has traced the legislative history of dependents' medical care from its inception to the present. The program began as a permissive, "only for emergency care in military facilities" type of benefit. It has developed into a legal right under which the dependents of active duty and retired or deceased persons and retired military members must be provided health care at either a military medical facility at no cost or at a civilian medical facility at minimal cost to the patient.

The legislative history chapter detailed the various proposals to Congress, the types of testimony for and against these proposals, and the resultant Congressional action. This demonstrated the interactions between Congress, the Department of Defense, and the civilian organizations such as the American Medical Association.

The chapter on the OCHAMPUS organization provided a picture of the administrative process presently used to manage the complex program. The description of claims processing provides an idea of how program contractors, providers and administrators interact with the beneficiaries and the health care providers.

Considerable thought has been given to having OCHAMPUS perform all of the claims processing actions presently accomplished by Blue Cross, Mutual of Omaha and the several

Blue Shield and State Medical Societies. On the surface this suggestion seems feasible but further consideration proves it to be impracticable. If OCHAMPUS were to process all claims, their present computer facilities would be woefully inadequate. To expand their facilities would require several million dollars. Another factor is the number of persons required to review all the claims. Regardless of how sophisticated a computer setup is used, people are still needed to do the manual phases of the processing. The several CHAMPUS fiscal intermediaries process over 265,000 claims per month. To do this approximately 670 persons are employed by these contractors. Still another factor is the CHAMPUS requirement of maintaining a personal history file. These files, even when on computer tape, occupy a large amount of space. This would mean that OCHAMPUS would have to expand its storage area, which in time, would mean additional investment in equipment and buildings as well as more people.

Other factors, such as maintenance of provider profiles and claims activity and audit files, would take more space, equipment and personnel. It is thought that these files would not be as comprehensive nor as accurate as the ones currently maintained by fiscal intermediaries. For example, Blue Shield of California maintains a provider profile on every physician in the State of California. This profile allows them to accurately determine area "customary" fees. If OCHAMPUS maintained such a profile system, it would be

comprised of only those providers who accepted CHAMPUS patients and thus the area "customary" fees would be composed of a smaller number of providers and would, most likely, be not as accurate.

The chapter on the budgeting for the CHAMPUS Program outlines other problems associated with administering a program as vast as the CHAMPUS Program. It is quite evident that the costs of this program are rising and at a rapid rate. Until the past year the price increases associated with inflation could be fairly accurately predicted. The number of eligible persons can be accurately predicted. It is more difficult, however, to estimate how many persons will utilize the program's benefits in future years. It is equally difficult to predict how many times in a year a single person will use the program, for how long, and at what cost.

The remaining chapter which discussed the CHAMPUS Phaseback Data Report were meant to be descriptive of the overall CHAMPUS reporting system. As mentioned in those chapter there is another report, a quarterly statistical summary. These reports are published for the managers of the CHAMPUS Program. In that regard they receive a limited distribution. Less than 60 copies of the report are published. Each of the Surgeon Generals receive the report, the Comptrollers of each of the services receive the report, and the Assistant Secretary of Defense receives the report. The CHAMPUS Phaseback Data is, as has been discussed above,

difficult to read. Even if one assumes a basic knowledge of the CHAMPUS Program it is difficult to read and interpret the report. Indeed, it seems that the only part of the report one could readily utilize is that section that pertains to costs. It is the author's understanding that the Quarterly Statistical Summary is in a similar format. (A copy of this report was not made available for the study.) One then wonders if this data is in a format which can be readily utilized by these managers. When one considers the difference in the FY 1976 budgets discussed above, it becomes apparent that the reports are not interpreted the same by the various agencies. It is, therefore, the author's opinion that there is room for improvement in the report format.

As of January 195, the CHAMPUS Program was in the throes of change. Nearly all of the changes resulted from the increased interest on the part of the members of the U. S. Congress. The current CHAMPUS appropriation is funded with a specific dolla· ceiling. The Assistant Secretary of Defense (Health and Environment) is under Congressional mandate to get the program's costs under control. Some possible ways to do this is to reduce the allowable benefits, change benefits from one cost category to another, or to stop all benefits when the dollars run out. The latter is clearly not a feasible alternative. Thus, policy changes in the arena of the first two alternatives have been made.

Other methods of cutting program costs are being studied by several groups including the Surgeon Generals, the Assistant Secretary of Defense and the Office of Management and Budget. These studies are primarily concerned with the better management of the program. It is the author's opinion, however, that the program's management, at least at the OCHAMPUS level, is quite good. The staff at OCHAMPUS is concerned about the costs and is striving to find ways of reducing them. The introduction of the Word Processing System has reduced the number of secretarial persons needed to prepare reports. They are in the process of computerizing the Finance and Accounting Division. This step will serve to reduce the contractor invoice processing time. The Contract Administration Division is constantly monitoring claims processing activities of the contractors and working with them in an effort to reduce the claims backlog. The Liaison Division is striving to better educate the beneficiaries as to allowable benefits of the program.

On top of the budget limitations are the effects of inflation. Budgetary guidelines required that the Fiscal Year 1976 budget be held at the level of the Fiscal Year 1975 budget. In view of the double-digit inflation in the nation, and especially in the health care industry, such a requirement makes any budget figure obsolete almost before the ink is dry.

That this program is complex cannot be denied. It has three management levels, i.e., ASD, OCHAMPUS, and fiscal intermediaries that do not always know what each other's needs are. The amount of paperwork necessary to "manage" this program is, although considerable in bulk, not completely unmanageable. It would seem that the CHAMPUS Program, as it is presently structured, does little in allowing the beneficiary a voice in its operation. True the beneficiary does have the freedom of choice as to whether he goes to a military or civilian facility but once that choice is made, he has no further voice in the program's operation. There is nothing in the CHAMPUS Program that encourages the beneficiary to shop around for the best available care at the lowest price. This facet of the program's management could use more emphasis.

There are a couple of subject areas that need further study. Both the budgetary and the accounting processes can stand more indepth study. As was apparent from this study, it is very difficult to match budgeted dollars with expended dollars. It is hoped that another such study in these subject areas could provide more understanding on these subjects. Another area which is in need of more study is the organizational relationships which are in existence at the Office of the Assistant Secretary of Defense. Further study of these relationships may provide some valuable insight into the policy decision-making process and, in turn, may assist those

in CHAMPUS management to better understand their role and the goals of the CHAMPUS Program.

APPENDIX A

SUMMARY OF DEPENDENT MEDICAL CARE LEGISLATION

1799 - "An Act in addition to "An Act for the Relief of Sick and Disabled Seamen" (a)", 2 March 1799.
Established that active duty and retired personnel of the Navy and Marine Corps would have deducted from their pay a sum of twenty cents per month to provide for their care if they became sick or disabled.

1811 - "An Act Establishing Naval Hospitals," 26 February 1811.
Provided that funds from above law were to be used to form a "fund for Navy Hospitals." Further provided that active duty and retired Navy and Marine Corps personnel could be admitted to these hospitals.

1884 - "Appropriations Act for the Army," 5 July 1884.
Contained a proviso in Medical Department Appropriations to allow Army Medical Officers to treat families of officers and enlisted men without charge.

1899 - "An Act to reorganize and increase the efficiency of the personnel fo the Navy and Marine Corps of the United States," 3 March 1899.
This act, in Section 13, stated that commissioned officers were to receive the same pay and allowances as Army officers of equal rank. This was interpreted by the Navy as allowing Navy Medical Officers to treat active duty dependents in Navy medical facilities.

1943 - "An Act to provide for the expansion of Navy medical facilities," Public Law 51, 10 May 1943.
This act defined the word "dependent" and spelled out that care was to be provided for "only acute medical and surgical conditions."

1956 - "Dependent Medical Care Act," Public Law 84-569, 7 June 1956.
This was the basic program for dependent medical care. Major points were (a) patient payment of $25 for inpatient care from civilian sources, (b) inclusion of maternity care from civilian sources as a benefit, and (c) retired and their dependents could use military facilities.

1956 - "Amendment to Title 10, USC," 10 August 1956.
This amendment, in essence, codified the above law as part of Title 10, United States Code.

1958 - "Amendment to Title 10, USC," 2 September 1958.
This amendment changed the purpose statement and added a special case consideration for inpatient care for nervous and mental and chronic conditions.

1965 - "Amendment to Title 10, USC," 16 September 1965.
This amendment provided that future military hospital construction should include facilities for obstetrical care.

1966 - "Military Medical Benefits Amendments of 1966," Public Law 89-614, 30 September 1966.
These amendments to the basic law provided for outpatient care for active duty dependents, made provisions for care (inpatient and outpatient) for mental and physically handicapped dependents of active duty and provided for civilian inpatient and outpatient care for retired military personnel and their dependents.

APPENDIX B

OPERATION AND MAINTENANCE, ARMY
BUDGET SUBMISSION, FY 1974

Total Operation and Maintenace, Army ----------$7,548,913

rogram 8: Training, Medical, and Other
General Personnel Activities ---------- 1,726,710
Budget Program: Medical Programs ---------- 644,300

Appropriation: Operation & Maintenance, Army	Actual FY 1972	Estimate FY 1973	Estimate FY 1974
Budget Pgm, Pgm Element, or Bud Proj Acct. 81214 Medical Care in Non-Service Facilities (Executive Director)	$141.367	$178,555	$206,627

JUSTIFICATION.

Section 1 - Purpose and Scope

This program provides for the administration of the Uniformed Services Health Benefits Program by The Surgeon General of the Army as Executive Director. Medical care is provided to the Dependents' Medical Care Act (10 U.S.C. 1071-1087) as modified by Section (25) of Public Law 85-861 and 89-614. Included is inpatient and outpatient medical care furnished dependents of active duty personnel, retirees, and dependents of retired and deceased of the Uniformed Services in civilian facilities in the United States, Puerto Rico, Canada and Europe. Included also is a program of health services, training and special education and rehabilitation for handicapped dependents of active duty personnel.

Section 2 - Justification

The fund requirement for the Army portion of Uniformed Services Health Benefits Program for Fiscal Year 1974 amounts to $206,627,000 and is based upon the most recent experience, optimum utilization of the Uniformed Services facilities, and the fact that dependents residing apart from sponsor may, by law, choose between federal and civilian hospitals. The following reflects the development of the fund requirement:

	FY 1972	FY 1973	FY 1974
Estimated Population	2,560,258	2,495,921	2,507,241
Dependents, Active Duty	1,483,248	1,495,921	1,312,276
Dependents, Retired and Deceased	730,400	779,600	810,732
Retired Members	346,610	367,123	384,233
Total Average Daily Patient Load	3,545	3,884	4,076
Dependents, Active Duty	1,920	1,910	1,900
Dependents, Retired and Deceased	1,225	1,460	1,600
Retired Members	400	514	576
Patient Days	1,297,470	1,417,660	1,487,740
Dependents, Active Duty	702,720	697,150	693,500
Dependents, Retired and Deceased	448,350	532,900	584,000
Retired Members	146,400	187,610	210,240
Cost Per Patient Day			
Dependents, Active Duty	$106.41	$113.33	$120.70
Dependents, Retired and Deceased	60.13	64.04	68.20
Retired Members	75.65	80.57	85.81
	In Thousands of Dollars		
Cost to the Federal Government			
Inpatient:			
Dependents, Active Duty	$ 74,776	$ 79,008	$ 83,705
Dependents, Retired and Deceased	26,959	34,127	39,829
Retired Members	11,075	15,116	18,041
Total Inpatient	($112,810)	($128,251)	($141,575)
Outpatient Care Costs	12,153	19,699	22,582
Drugs	1,750	3,017	3,871
Handicapped	2,712	3,762	3,989
Dental	4,102	12,500	21,976
Europe	1,500	2,900	2,000
Total Medical Care Costs	($135,027)	($170,129)	($196,893)

Administrative Costs	($6,340)	($8,426)	($9,734)
Claims Processing Costs	4,340	6,413	7,757
CHAMPUS Office	2,000	2,013	1,977
Total Requirements	$141,367	$178,555	$206,627

Section 3 - Summary of Budget Changes

	In Thousands of Dollars	
FY 1973 Estimate		$178,555
Reductions		
1. One-time Management Study of Health Maintenance Organizations	$57	
2. Reduction in Average GS grade	12	
Total Reductions		-69
Increases		
1. Continued Rise in medical care costs	$9,154	
2. Increased medical workload	18,954	
3. Annualization of graded pay raises	33	
Total Increases		28,141
FY 1974 ESTIMATE		$206,627

APPENDIX C

OPERATION AND MAINTENANCE, NAVY
BUDGET SUBMISSION FY 1974

Total Operation and Maintenance, Navy..... $6,694,479

Direct Program 8: Training, Medical, and Other General Personnel Activities..... 820,676

Budget Program E: Medical Support..... 360,931

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Budget Program E: Medical Support:
(1) Hospital Operations
(2) Care in Non-Service Facilities:

	(In Thousands)
FY 74 Est	$189,039
FY 73 Est	169,238
FY 72 Act	139,020

This budget program provides funds for inpatient and outpatient care of active duty and retired Navy and Marine Corps personnel and their dependents in other than service facilities. The funds requested for this purpose are based on fiscal year 1972 actual experience applied to planned Navy and Marine Corps strengths and estimated number of eligible dependents in fiscal year 1974, using prescribed charges for hospitalization and treatment where applicable. The increase requested in FY 74 is due to increased utilization of the CHAMPUS Program in addition to the continuing increased cost of private medical care. Workload and fund requirements for this program are as follows:

	(Ave. daily Pts)			(Obligations)		
	FY72 ACT	FY73 EST	FY74 EST	FY72 ACT	FY73 EST	FY74 EST
CONTRACTED MEDICAL CARE:				$129,361	$159.003	$178,447
Inpatient Care	3,062	3,326	3,594	101,032	120,005	178,447
Outpatient Care				13,324	17,944	19,277
Retarded & Handicapped Contractor's Services & Fees, Drugs, Dental and Other Costs				2,975 12,030	3,979 17,075	4,597 19,400
OTHER NON-SERVICE CARE:				$ 9,659	$10,235	$10,592
Inpatient Care	317	314	315	7,631	8,085	8,343
Outpatient Care				2,028	2,150	2,249
Total Care in Non-Service Facilities	3,379	3,640	3,909	$139,020	$169,238	$189,039

Source: House of Representatives, Committee on Appropriations, Subcommittee on Defense Hearings, Ninety Second Congress, Second Session. 1973

APPENDIX D

OPERATION AND MAINTENANCE, AIR FORCE
BUDGET SUBMISSION FY 1974

Total Operation and Maintenance, Air Force..... $7,118,800

Direct Program 8: Training, Medical, and Other
General Personnel Activities..... 953,225

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Force Program VIII:

A. Training and Other General Personnel Activities.			
B. Medical.	72 Act	73 Est	FY 74 Est
1. Medical Operations	$165,315	$165,527	$177,935
2. Medical Care in Non-Service Facilities	126,202	163,356	209,835
In Thousands Subtotal	$291,517	$328,883	$387,770

- -

Force Program VIII, B., 2.:
Medical Care in Non-Service Facilities

The estimate of $209,835 thousand for medical care in non-service facilities provides for furnishing medical care to active duty and retired Air Force military personnel and their authorized dependents in facilities of the Veterans Administration, Public Health Service, Canal Zone, and in civilian medical facilities.

Fund requirements are summarized as follows: (In Thousands of dollars)

	FY 72 Actual	FY 73 Estimate	FY 74 Estimate
Medical Care in Non-Service Facilities (CHAMPUS)	$118,784	$155,548	$201,735
Medical Care in Non-Service Facilities (OTHER)	7,418	7,808	8,100
Medical Care in Non-Service Facilities (TOTAL)	$126,202	$163,356	$209,835

Major Funding Change From FY1973 to FY1974 - $+46,479:

The increase results from growth in population of retired military personnel and their dependents who become eligible for Civilian Health And Medical Program Uniformed Services (CHAMPUS) benefits, and increased use of the CHAMPUS by all eligible beneficiaries, and the rising costs in medical care obtained from the civilian community.

Source: House of Representatives, Committee on Appropriations, Subcommittee on Defense Hearings, Ninety Second Congress, Second Session. 1973

APPENDIX E

CHAMPUS DIALOGUE
HOUSE OF REPRESENTATIVES
COMMITTEE ON APPROPRIATIONS
SUBCOMMITTEE ON DEFENSE, FY 1974

Mr. Flynt[1]: Your statement (prepared statement on Operation and Maintenance, Army Budget) indicates that CHAMPUS program for fiscal year 1974 has been overfunded from $25 to $35 million. We have discussed the funding of the CHAMPUS program in the committee for many years. Past experience has always shown that this program is completely underfunded. How is it that in fiscal year 1974, the Army has so substantially overfunded the program?

Colonel Kiely[2]: Sir, our actual experience in fiscal year 1973 has indicated to us that CHAMPUS costs are continuing to rise. But they are rising at a slower rate than initially contemplated. The 1974 projection of $172 million is $21 million greater than the 1973 estimated requirement of $151 million. The increase in CHAMPUS continues but not as fast as we had previously thought

Mr. Flynt: Was CHAMPUS overfunded or underfunded in fiscal year 1973?

Colonel Kiely: In fiscal year 1973, in tracking our CHAMPUS growth, we first discovered that CHAMPUS requirements were not beginning to reach the funds which we had programmed and budgeted for that activity. Some of the CHAMPUS funds in 1973 were utilized to meet our currency revaluation problem.

Mr. Flynt: Is that what you did with the excess funds?

Colonel Kiely: In the reprogramming, yes.

Mr. Garrity[3]: What was the total amount of excess CHAMPUS funds?

Colonel Kiely: It is in the reprogramming table, sir--$23,286,000 in Program 8. In the reprogramming request for the CHAMPUS funds, sir, for CHAMPUS itself, $20,325,000.

Mr. Flynt: Can you explain the difference between that amount and the $23.8 million that you mentioned earlier?

Colonel Kiely: I was adding training funds in that sir.

Mr. Flynt: In other words, the correct amount is $20,325,000?

Colonel Kiely: Yes, sir.

Mr. Flynt: What was the original budget request for CHAMPUS for fiscal year 1974 as compared to the revised amount that you are now asking?

Colonel Kiely: For CHAMPUS, we had an original program of $206.6 million for fiscal year 1974.

Mr. Flynt: And you are now reducing it to what?

Colonel Kiely: $171.8 million which is $34.8 million under the fiscal year budget estimate.

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The following information was furnished for the record.

"The following are the revised Army estimate, both workload and cost for CHAMPUS in fiscal year 1974."

	(Thousands)
Average daily patient load	
Dependents, Active Duty	$ 1,710.00
Dependents, Retired and Deceased	1,742.00
Retired Members	568.00
Cost Per Patient Day	
Dependents, Active Duty	$ 110.74
Dependents, Retired and Deceased	$ 63.48
Retired Members	$ 85.60
Inpatient Care Costs:	
Dependents, Active Duty	$69,118.00
Dependents, Retired and Deceased	40,362.00
Retired Members	17,747.00
Total Inpatient Costs	$127,227.00
Outpatient Care	18,355.00
Drugs	2,956.00
Handicapped	3,473.00
Dental	8,077.00
Europe	3,760.00
Administrative Costs	7,947.00
Total Army Costs	$171,795.00

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[1]Mr. John J. Flynt, Democrat, Georgia.

[2]Colonel John W. Kiely, U.S. Army, Assistant Director of Army Budget for Operation & Maintenance, Office of the Comptroller of the Army.

[3]Mr. John M. Garrity, Staff Assistant, Committee on Appropriations, House of Representatives.

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